DOCUMENT RESUME

ED 452 992 PS 029 496

TITLE	A State Call to Action: Working To End Child Abuse and Neglect in Massachusetts.
INSTITUTION	Massachusetts KIDS COUNT, Boston.
SPONS AGENCY	Annie E. Casey Foundation, Baltimore, MD.
PUB DATE	2001-04-00
NOTE	186p.; Additional support was provided by the Frank Reed and Margaret Jane Peters Memorial, and by Jane B. Cook.
PUB TYPE	Opinion Papers (120)
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	Adoption; Alcoholism; Change Strategies; *Child Abuse; Child Development; *Child Neglect; *Child Welfare; *Children; Family Violence; Foster Care; Homeless People; Incidence; Intervention; Legal Problems; Prevention; Sexual Abuse; *Social Services; State Programs; Substance Abuse; Well Being
IDENTIFIERS	Child Protection; Massachusetts

ABSTRACT

Although Massachusetts ranks in the top 10 percent among states on several key indicators of child well-being, the state's growing incidence of child maltreatment is stark and confounding. This report launches a state call to action aimed at ending child maltreatment through revising and strengthening systems to protect children, providing support and education for families of young children to prevent abuse/neglect, and providing therapeutic and other services to allow abused/neglected children and their families to recover as fully as possible. The report is presented in six sections. Section 1 presents information on the incidence of abuse/neglect and its impact on children. Section 2 examines key causes and links between abuse and domestic violence, substance abuse, and homelessness. Section 3 addresses key proposals to modify the child protection network, including developing a multi-track system for differential response to abuse/neglect cases, depending on seriousness. Section 4 details recommendations for improving treatment and support for abused/neglected children and their families, including promoting schools as safe havens and healing places for abused, neglected, and traumatized children. Section 5 focuses on prevention, proposing the building of a strong infrastructure of family supports across the state to address family needs early so that state intervention could be avoided or reduced. Section 6 identifies child maltreatment as the common denominator underlying serious social problems that translate into enormous fiscal costs for society; the section calls for a commitment to ensure effective treatment for abused/neglected children, to strengthen state systems charged with the care and protection of these children, and to expand family support and prevention services significantly. The report's three appendices detail the activities of work groups related to the Summit Initiative on Child Protection and Family Support, list the participants of the Summit Initiative, and delineate child maltreatment numbers by city/town in Massachusetts for 1997. (Contains 292 endnotes.) (KB)

Reproductions supplied by EDRS are the best that can be made
from the original document.

A State Call To Action:

Working to End Child Abuse and Neglect in Massachusetts

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

1

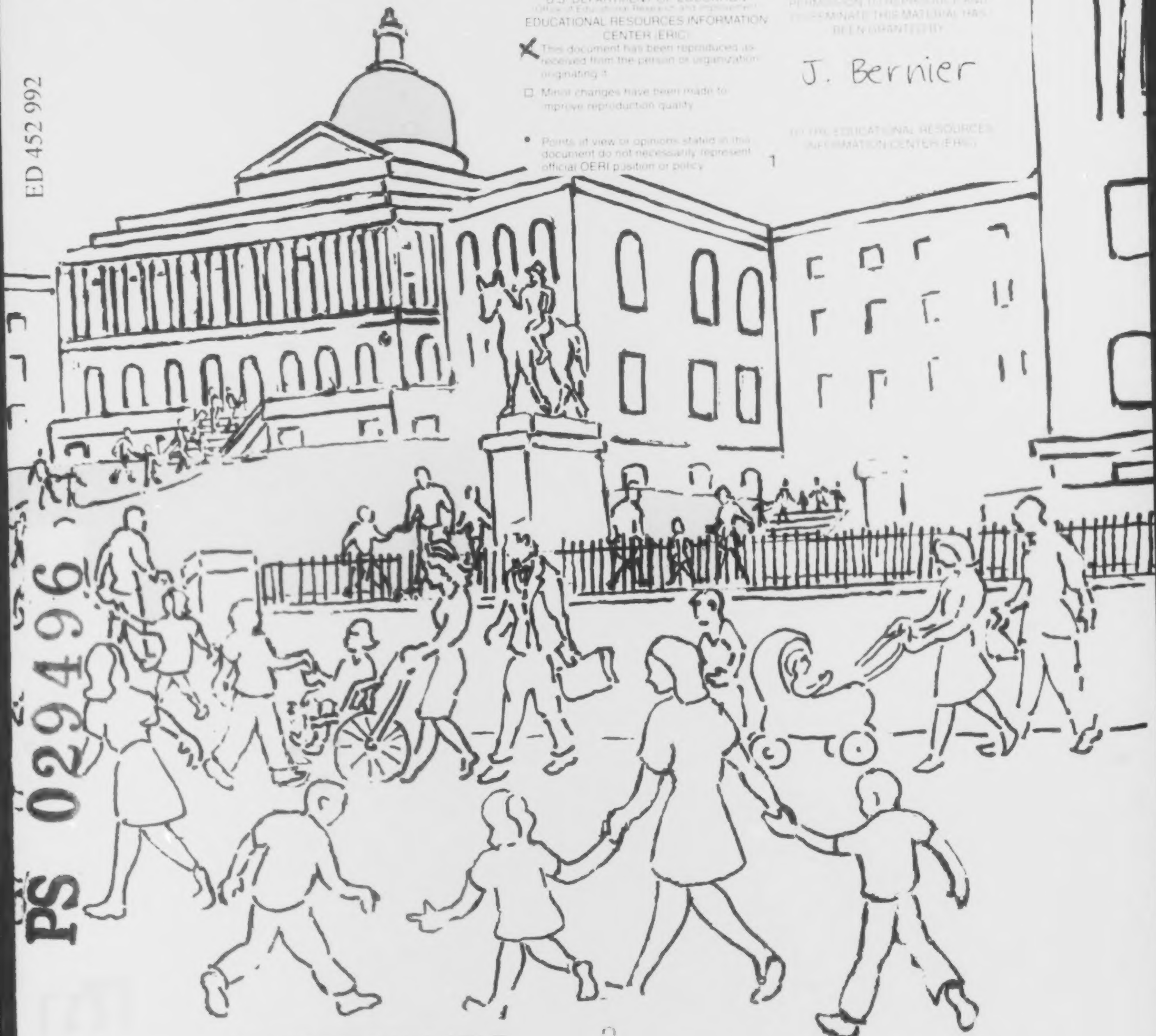
PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

J. Bernier

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

ED 452 992

PS 029496



BEST COPY AVAILABLE

Massachusetts Citizens for Children

A STATE CALL TO ACTION:

Working to End Child Abuse and Neglect in Massachusetts

Massachusetts Citizens for Children

April 2001

This report was made possible through a grant by the Annie E. Casey Foundation and its Kids Count initiative. Additional support was provided by the Frank Reed and Margaret Jane Peters Memorial, and by Mrs. Jane B. Cook.

Massachusetts Citizens for Children

Massachusetts Citizens for Children (MCC) is committed to improving the lives of our state's most vulnerable children. Through its program **Prevent Child Abuse Massachusetts**, MCC is working to end child abuse and to build family supports across the state. Its 2,000-member **Campaign for Children** educates and mobilizes citizens to speak out for needed children's policies and programs. **Kids Count** project, part of a state-by-state data initiative of the Annie E. Casey Foundation, helps Massachusetts monitor the status of its children on several indicators of well-being. MCC is the Massachusetts member of the **National Association of Child Advocates**, the only national network of state-based child advocacy groups. An independent organization, MCC accomplishes its goals through public education, citizen action, legislative advocacy, public opinion polling, and through the media.

Prevent Child Abuse Massachusetts

Massachusetts Campaign for Children

Massachusetts Kids Count

National Association of Child Advocates

Charles Welch, MD, President
Director, Somatic Therapies Center, Massachusetts General Hospital
Vice President, Massachusetts Medical Society

Jetta Bernier, Executive Director

Board of Directors

Melanie Andrews, Assistant Vice President, Citizens Bank of Massachusetts
Lindsay Boutros-Ghali, Lindsay Architecture Associates
Linda Cutting, Author and Concert Pianist, The Longy School of Music
Louis DiNatale, Director of the Center for State and Local Policy,
John W. McCormack Institute of Public Affairs, University of Massachusetts, Boston
Richard A. Goodman, PhD, MEd, Certified Psychoanalyst
Mitch Gross, Vice President of Business Services, Staples.com
Gordon Harper, MD, Medical Director, Children and Adolescent Services,
Massachusetts Department of Mental Health
Stephen P. Johnson, Esq., Senior Fellow, The Philanthropic Initiative
Philip W. Johnston, President, Philip W. Johnson Associates and former Secretary,
Massachusetts Executive Office of Health and Human Services (EOHHS)
Katharine Kane, Private Citizen and former Deputy Mayor of Boston
Max Kargman, Chairman, First Realty Management Corporation
Roderick K. King, MD, Director, Boston Field Office, Health Resources and Services
Administration, US Department of Health and Human Services
Hugh M. Leichtman, PhD, Administrative Director, Wediko Children's Services
John Lippitt, Research Associate, Early Childhood Policy Group,
Family and Child Policy Center, Heller School, Brandeis University
Stephen Lorch, Private Management Consultant
Claire McCarthy, MD, Pediatrician, Martha Eliot Health Center; and Author
Alan Nash, President, Crackle Creations
Eli Newberger, MD, Assistant Professor of Pediatrics, Harvard Medical School
Lecturer, Maternal and Child Health, Harvard School of Public Health, and Author
Maureen Pompeo, President, Galloglass Consulting
Thomas N. Trkla, President, Brookwood Financial Partners
Ron White, PhD, Associate Director, Bear Stearns Company
John Woodall, MD, Director, The Unity Project

Copyright© 2001 Massachusetts Citizens for Children, 14 Beacon Street, Suite 706,
Boston, MA 02108 ~ Phone: 617-742-8555 ~ Fax: 617-742-7808 ~ www.masskids.org
Permission to reproduce portions of this report is granted provided
Massachusetts Citizens for Children - Kids Count is cited as the source.

Cover illustration courtesy of Paul Shea, renowned Boston artist and friend of MCC, to whom we owe our sincerest thanks for his generosity.

Table of Contents

Foreword 7

Acknowledgements 9

Introduction 11

Executive Summary 15
- Section I. ~ Incidence and Impact 15
- Section II. ~ Key Causes and Links 16
- Section III. ~ Protecting Our Children 19
- Section IV. ~ Healing Our Children 21
- Section V. ~ Preventing The Hurt 22
- Section VI. ~ Taking Action 23

SECTION I. INCIDENCE AND IMPACT OF ABUSE AND NEGLECT ON CHILDREN 27

CHAPTER 1
Incidence and Prevalence 29
- Who Are These Children? 30
- Neglect 31
- Physical Abuse 32
- Sexual Abuse 33
- Emotional Abuse 35

CHAPTER 2
Impact of Abuse and Neglect on Child Development 37
- Impact of Abuse and Neglect on Early Brain Development 38
- Immediate and Long Term Behavioral Effects of Abuse and Neglect 39
- Trauma and Learning 40
- Resiliency and Early Intervention 40

SECTION II. KEY CAUSES AND LINKS 43

CHAPTER 3
Children Living in Homes With Domestic Violence 45
- Co-occurrence of Child Abuse and Domestic Violence 45
- Integrating Child Welfare and Domestic Violence in Massachusetts 47
- RECOMMENDATIONS 48

CHAPTER 4
Children Living With Parental Alcohol and Substance Abuse 51

Substance Abuse and Child Neglect, Physical Abuse, and Sexual Abuse 52
The Fiscal Burden 54
RECOMMENDATIONS 56

CHAPTER 5
Children Living Without Homes 57
Homelessness and Child Neglect 57
Homelessness and Mental Health Problems 59
Homelessness and Educational Neglect 60
Homelessness and Substance Abuse 60
RECOMMENDATIONS: 61

SECTION III. PROTECTING OUR CHILDREN 65

CHAPTER 6
The Child Protection System 67
A Brief Overview of the Massachusetts System 67
Conventional Child Protective Services 69

CHAPTER 7
Multi-Tracking: A Differential Response System 71
Missouri's Dual-Track Approach 72
The Federal Mandate: The Adoption and Safe Families Act (ASFA) 73
Proposal for a Multi-Track System for Massachusetts 73
RECOMMENDATIONS 78

CHAPTER 8
Multidisciplinary Assessment: The Core of Effective Practice 81
Child Protection Teams of Florida 83
Massachusetts Teams 85
Sexual Abuse Investigative Network Teams [SAIN TEAMS] 86
Children's Advocacy Centers [CACs] 88
Hospital-based Child Protection Teams (CPTs) 90
Multidisciplinary Assessment Teams [MDATS] 91
Multidisciplinary Assessments and the Courts 95
RECOMMENDATIONS 96

CHAPTER 9
Workforce and Workload: The Foundation of Quality Child Protection 101
Workforce and Workload 101
Salaries and Staff Turnover 102
Caseloads 102
Education, Recruitment and Training 103
Child Protective Services Training Institute 104
Licensing of Social Workers 104
RECOMMENDATIONS 105

CHAPTER 10
Abused and Neglected Children in Foster Care 109
Multiple Placements 110
Foster Home Supply 110

Children Transitioning Out of Foster Care 111
Timeliness of Placements 111
RECOMMENDATIONS 111

CHAPTER 11
Abused and Neglected Children and Adoption 115
RECOMMENDATIONS 115

CHAPTER 12
Accountability in the Child Protection System 119
Citizen Review Panels 119
Professional Advisory Committee 119
Child Death Review Teams 120
RECOMMENDATIONS 121

CHAPTER 13
Abused/Neglected Children and the Courts 123
Information Sharing Among Courts 123
Reporting of Child Abuse Allegations by the Courts 124
Guardians Ad Litem 125
Assessment Teams and the Courts 126
Court-Friendly Practices For Child Victim Witnesses 128
Judicial Training in Child Protection 129
Jeremy and Isaac 129
RECOMMENDATIONS 130

SECTION IV. HEALING OUR CHILDREN 133

CHAPTER 14
Treatment and Intervention: The Essentials to Healing 135
The Mental Health Care Crisis in Massachusetts 135
Innovations in Trauma Treatment 137
RECOMMENDATIONS 140

CHAPTER 15
The Role of Schools in the Life of the Traumatized Child 143
RECOMMENDATIONS 144

SECTION V. PREVENTING THE HURT 151

CHAPTER 16
Family Support: The Critical Paradigm Shift 153
The Family Support Philosophy 154
Traditional Services and Family Support 156
Parental Involvement in Decision Making 156
The Effectiveness of Family Support 158
DSS Family Support Programs 159
RECOMMENDATIONS 161

CHAPTER 17

Child Abuse Prevention: Within Our Reach 163
Other State-Based Prevention and Family Support Efforts 163
Prevention and Family Support in the Private Sector 165
Shaken Baby Syndrome Prevention 169
Child Sexual Abuse Prevention and Treatment 170
RECOMMENDATIONS 171

SECTION VI. TAKING ACTION 175

CHAPTER 18

Social and Fiscal Costs of Child Abuse and Its Consequences 177
Links between Abuse/Neglect and Juvenile Delinquency 177
Links between Child Abuse and Adult Disease 178
Links between Child Abuse/Neglect and Welfare Dependency 179
Fiscal Costs to our Nation 179

CHAPTER 19

Options for Funding Reform 181
Potential Funding Sources 182

CHAPTER 20

Next Steps 185

Conclusion 187

Endnotes 191

Appendix A

The Summit Initiative on Child Protection and Family Support 201

Appendix B

Summit Initiative Participants 1999-2001 205

Appendix C

Unduplicated Counts of Reported Children by Incorporated City/Town during January 1 – December 31, 1997 211

Foreword

By national standards children in Massachusetts are among the most fortunate in the country. Massachusetts ranks in the top ten percent among states on several key indicators of child well-being. Public health advances have made our child death rate for children ages 1 to 14 the lowest in the nation and our infant mortality rate third among states.

However, contrast between the state's overall progress and the incidence of child maltreatment is stark and confounding. In the decade from 1987 to 1997, Massachusetts saw an 98 percent increase in the number of children reported for abuse or neglect, compared to a national increase of 54 percent during the same period. Based on the latest data, roughly 46 of every 1,000 children in our state is involved each year in a child abuse or neglect report. Each year, thousands of newborn children in Massachusetts go home from hospital only to return later with unthinkable injuries – injuries that for most will be life-changing and for some will be life-ending.

Although Massachusetts ranks consistently in the top three to four states in per capital income, we have been unable to translate this extraordinary wealth into reductions in childhood poverty, family violence or child maltreatment. States with fewer resources but clear vision are leading a national reform of child protection that is innovative, pro-active and effective.

Since May 1999, over 200 Massachusetts policymakers and advocates have participated with Massachusetts Citizens for Children in the "Summit Initiative on Child Protection and Family Support." Motivated by a shared belief that overall current systems do not reflect our state's deep and longstanding commitment to improving children's lives, they collaborated to achieve a consensus for change. This **State Call To Action** reflects their collective vision on how Massachusetts can successfully deal with child maltreatment and reclaim its historic role of leadership in meeting the essential needs of all its children.

Charles Welch, M.D., *President*
Massachusetts Citizens for Children

Acknowledgements

We extend a heartfelt thanks to the many dedicated child and family advocates, representing a range of disciplines and expertise, who participated in the Summit Initiative. We are inspired by the vision they helped shape and are moved by their enduring commitment to the children and families of our state.

To the many state agency leaders and staff who have been a part of this process, MCC extends its deep appreciation. In particular, we wish to thank Department of Social Services (DSS) Commissioner Jeffrey Locke for engaging openly and constructively in this important process. The commitment to children exemplified by these public servants should give us all great pride.

Without support from the Annie E. Casey Foundation, this initiative would not have been possible. The Foundation's solid commitment to child advocacy that is data-driven and to public policy that builds family and community supports has inspired our critical work in these areas. We thank our local donors also, whose support of MCC helped this small organization sustain its big vision.

Our appreciation extends to the Edna McConnell Clark Foundation for its technical assistance during the early phase of this initiative in the spring of 1999, and to Prevent Child Abuse America and its state chapters for their assistance as we worked to develop strategies to fund the recommendations in this report. A special thanks to the National Association of Child Advocates and our member colleagues across the country whose passion for fairness for children always translates into the highest level of technical assistance.

We are grateful to our colleagues from across the country for their vision in conceiving and launching the National Call To Action to End Child Maltreatment, and to our colleagues from other states, including Missouri, Florida, Iowa, Vermont, who graciously shared their local successes and challenges with us. In doing so, they remind us that people throughout the country are bonded in their common commitment to strengthen families and end the abuse and neglect of our nation's children. We intend to build on their work.

Introduction

> *Justice, dignity, equality—these are words which are often used loosely, with little appreciation of their meaning. I think that their meaning can be distilled into one goal: that every child in this country live as we would want our own children to live.*
>
> **Robert F. Kennedy**
> New York, 1965[1]

Despite nearly three decades of legislatively mandated child protection services in Massachusetts and across the country, the number of children reported and confirmed as victims of abuse and neglect each year remains alarmingly high. **From 1986 to 1997, the number of abused and neglected children jumped nationwide from 1.4 million to 3 million.** This increase reflected a rise *more than eight times faster than the increase in the children's population* (114.3 percent compared to 13.9 percent).[2]

The U.S. Advisory Board on Child Abuse and Neglect now estimates the number of child deaths at 2,000 each year - more than five deaths a day.[3] Child abuse is the leading cause of death in children under age 1, while children younger than 4 years of age account for over 75 percent of child abuse and neglect deaths.[4]

In Massachusetts over 60,000 reports of child abuse and neglect were filed in 1998, representing nearly 100,000 children. That year, 13 children who were known to the state child protection agency died - 8 from neglect, 2 from abuse, and 3 from both abuse and neglect.[5] This number does not include other children that died as a result of abuse or neglect but were not previously referred to child protective services. Particularly sobering is the fact that *while child maltreatment has been steadily growing in the Commonwealth over the past decade, other crimes of violence have shown a steady and dramatic decrease.*

The links between maltreatment and poor outcomes indicate that public health rather than criminal justice responses offer the most effective ways to reduce physical and psychological morbidity in our youngest citizens and in the U.S. population at large. Neighborhood-based family supports are among the most effective ways to reduce child abuse and neglect. The success of these family supports, however, is fundamentally linked to improvements in state child protection systems and to comprehensive efforts to prevent and treat child abuse.

A recent response to the persistently high incidence of child abuse and neglect nationally has been the National Call To Action to End Child Maltreatment, initiated by Children's Hospital and Health Center-San Diego at its January 1999 "Conference on Responding to Child Maltreatment." This effort to end child abuse and neglect has now brought together over 30 of the country's leading organizations in a coalition to address this national crisis.

With the release of our report, Massachusetts Citizens for Children (MCC) launches the first, parallel **State Call To Action** aimed at ending child maltreatment. Through our recommendations and the mobilization of citizens to support them, we will work to achieve three fundamental long-term objectives articulated by the National Call:

1. **PROTECTION**: Our systems of protecting children will be revised and strengthened to deliver the highest quality response.

2. **PREVENTION**: Families of our youngest children will receive the support and education necessary, so that their children will not be subjected to child maltreatment.

3. **HEALING**: Any child who is abused or neglected will receive the full complement of therapeutic and other services and support needed, as will their families, to recover as fully as possible from the effects of that maltreatment.

Summit Initiative on Child Protection and Family Support

The essential groundwork for these changes has been laid through the efforts of over 200 child and family policy leaders across Massachusetts who have participated with MCC in the "Summit Initiative on Child Protection and Family Support." (See Appendices A and B.) The initiative was launched by MCC in May 1999 with an intensive two-day meeting involving fifty policy leaders from Massachusetts and a dozen child protection and family support experts from across the country. It was followed by five active Working Groups that met regularly over six months beginning in January 2000 to focus on specific aspects of the current system.

In the spring of 2000 three daylong Symposia were held to discuss and develop recommendations to address the implications of child trauma on brain development, behavior, and school performance. Finally, meetings and consultations with leading national and state experts helped shape other critical recommendations. Throughout this period, Massachusetts leaders explored successful practices, debated strategies, and worked together to achieve a consensus agenda for change and improvements.

The Public's View

Recommendations of the **State Call To Action** are part of a comprehensive and evidence-based proposal for systemic reform – reform that is strongly supported by the public.

In a 1998 poll commissioned by MCC and its program, Prevent Child Abuse Massachusetts, **46% of the 400 citizens surveyed identified "safety from abuse, neglect, and violence" as the most important element necessary to child well-being.** Health care was second with 17%, followed by freedom from poverty (9%), education (9%), and childcare (4%).[6]

A subsequent survey conducted for MCC by the University of Massachusetts Poll in the spring of 2000 supported previous findings:[7]

- **88% consider child abuse/neglect a very serious (55%) or somewhat serious (33%) problem in Massachusetts;**
- **84% believe child abuse/neglect has a very significant (51%) or somewhat significant (33%) effect on a child's MCAS scores;**
- **57% think that more than half of abused/neglected children go on to develop behavior and learning problems.**

In responding to their view of how our state is currently addressing these issues:

- **60% believe the child protection system needs major reform;**
- **Health care professionals (50%) and non-profit advocacy organizations (25%) were most frequently identified as the groups whose ideas the public would most trust on reform issues.** Others included: law enforcement officials (11%), business leaders (4%), and political leaders/state officials (2%).

Results of a survey of voters conducted in 2000 by the Stride Rite Foundation to measure the public's support for early childhood education also reinforced the UMass results. In addition to documenting support for this critical educational goal, 54 percent of voters identified the need to reduce violence against women and children.[8]

Conclusion

The Summit Initiative on Child Protection and Family Support has crafted a consensus agenda among key professionals in child welfare, health, mental health, and law enforcement. As our discussions confirmed, the systems involved in preventing child abuse and in protecting and healing victimized children are complex. Multiple strategies, both short and long term, will be required to implement proposed solutions. Working together, however, we believe a strong, bi-partisan political will can be forged – one that will ensure today's children and generations to come a safe childhood and a future filled with hope.

In the months ahead, Massachusetts Citizens for Children will continue to bring together leaders and advocates to further refine the **State Call To Action**. We will work to educate, build, and mobilize the constituency for children by involving citizens, legislators, front-line workers, state officials, local faith leaders, the business community, and, importantly, those personally affected by child abuse and neglect. MCC will remain committed to providing leadership for the broad-based effort to end child maltreatment in Massachusetts until that vision is realized.

Jetta Bernier, Executive Director
Nora Sjoblom Sanchez, Esq.

April 2001

Executive Summary

Section I. ~ Incidence and Impact

Over the ten-year period from 1987 to 1997, **Massachusetts saw a 98 percent increase in the number of children reported for abuse or neglect - this in contrast to an increase of 54 percent nationally** during the same period. Based on Massachusetts' child population of 1.5 million in 1997 and the 100,000 children reported that year, we see that roughly **46 of every 1,000 children was involved in a child abuse report**. Statistics released to MCC for 1999 confirm a persistent and ever worsening problem of child abuse, even while the state's violent crime rate decreased 21 percent from 1993 to 1998.

In Massachusetts, substantiated child neglect comprises the largest number of cases at 68 percent. Physical abuse cases make up 24 percent; while sexual abuse comprises 6 percent and emotional maltreatment includes 2 percent of cases.

The impact of abuse and neglect on children is enormous. Brain research confirms that connections in the brain used repeatedly during the early years of a child's life become the life-long foundation of the brain's organization and function. By three years old, a child's brain has reached approximately 90 percent of its full potential. To reach this optimal stage, the brain requires good health and nutrition, as well as a great deal of stimulation.

Early abuse is extremely damaging to a child's developing brain. Failure to properly nourish a child, inflicting physical pain and injury, or simply ignoring the emotional needs of a small child can cause trauma. Such traumatized children often experience developmental delays across a broad spectrum, including cognitive, language, motor, and socialization skills.

Problems that abused and neglected children face as they grow into adulthood can include:

- Increased prevalence of drug or alcohol dependence
- Increased rate of status offenses—running away, truancy
- Delinquent behavior and adult criminal behavior
- Recurring health problems—physical and mental
- Growing up to repeat abusive and neglectful parenting behaviors

Maltreated children have greater behavioral problems and perform significantly worse in school. Many show signs of language or cognitive disability, exhibit learning disorders and require special education services at some time.

Most tragically, if the cycle of violence is not interrupted, child abuse can be perpetuated for generations. *Parents that abuse their own children, and the perpetrators of other forms of domestic violence, are frequently survivors of maltreatment in their own childhoods.*

Section II. ~ Key Causes and Links

Domestic Violence and Child Abuse

Estimates are that **between 3.1 and 10 million children witness acts of domestic violence each year.** Research also indicates that **30 to 60 percent of children from homes where domestic violence is present are also victims of abuse themselves.**

The co-occurrence of domestic violence and child abuse can compound even further the negative effects children are likely to experience over their lifetime. Health risks for children of parents engaged in domestic violence can begin even before birth. Estimates are that as many as 20 percent of pregnant women experience personal violence. The direct trauma or stress of abuse during pregnancy can lead to low birth weight, premature birth, and fetal distress, injury and death.

Researchers now know that children who see or hear a parent being battered can experience the same level of trauma as children who themselves are beaten. In one study, 93 percent of the children witnessing domestic violence were diagnosed with Posttraumatic Stress Disorder (PTSD). Long-term consequences for these exposed children can include higher rates for mental illness, drug abuse, and criminal justice involvement as an adult. Children exposed to domestic violence are also at greater risk for sexual abuse outside the home. *Domestic violence constitutes the single, major precursor for child maltreatment fatalities.*

Recommendations

The **State Call to Action** calls for increasing the number of Domestic Violence Specialists at DSS, expanding specialized treatment for child victims of domestic violence, and expanding domestic violence training for child welfare providers, school personnel, providers of medical care for women and children, and juvenile, family and criminal court personnel. The Massachusetts Department of Social Services can take pride in its leadership in coordinating training and practice to respond to cases involving child abuse and domestic violence. It must now work to ensure that these efforts are fully integrated locally across the state.

Substance Abuse and Child Abuse

The number of Americans who during their lives have been neglected and/or physically and sexually assaulted by substance-abusing parents is a significant portion of our population. Many experts believe that *substance abuse and addiction are the primary causes of the dramatic rise in child abuse and neglect and the startling increase in the complexity of cases since the mid-1980s.* **Children whose parents abuse drugs and alcohol are almost three times likelier to be abused and more than four times likelier to be neglected** than children of parents who are not substance abusers. Substance abuse causes or contributes to from 50 to 75 percent of all child maltreatment cases reported to state authorities. Children of substance-abusing parents are likelier to enter foster care and stay longer in care than other children.

Child neglect is a frequent problem among parents involved in these addictions. The use of precious resources to pay for drugs or alcohol often results in lack of food, heat, or adequate clothing for these children. Lack of supervision from addicted parents who spend extended hours or days outside the household, can have damaging psychological consequences for children and can place them in dangerous physical jeopardy, as well.

Sexual abuse among these children is not uncommon since they are often exposed to non-related addicted adults. Even when substance-abusing parents are in the home, their condition may not allow for any meaningful protection. Because alcohol leads to a lowering of inhibitions in many people, children of alcoholics face a higher risk of sexual abuse by their own parents. It is estimated that **between 30 to 40 percent of all reported incest cases involve an alcoholic parent.**

Sadly, many children are the victims of alcohol and drug abuse while they are still in the womb with 500,000 babies born each year having been exposed to illicit drugs and alcohol during pregnancy.

Children of substance-abusing parents are at high risk of developing their own substance abuse problems later on. For children growing up in these homes who are entering adolescence or adulthood, alcohol or drugs can be a way to cope with depression, low self-esteem and other psychological effects of their victimization. Their early use of substances may lead to aggressive, delinquent or anti-social behaviors that themselves create risks for substance abuse.

In Massachusetts over $300 million dollars were spent on child welfare services in 1998. *Nearly 76 percent of those dollars were spent on services provided to children because of conditions "caused or exacerbated by alcohol or drug abuse."*

Recommendations

The **State Call to Action** proposes the development of a comprehensive State Plan for Massachusetts aimed at preventing alcohol and substance abuse and treating affected parents and children. Convened by an appropriate state agency or the legislature, and coordinated with efforts to prevent and treat child abuse, the plan would identify strategies to prevent the abuse of substances within the adolescent and young adult population; ensure comprehensive treatment of affected parents and children; and establish training programs for workers in the social services, health care and judicial systems.

The high number of child abuse cases in which alcohol or substance abuse is a major cause or contributor makes it imperative that DSS now develop expertise to improve outcomes for children and families affected by these addictions. Using the same successful strategies that have made it a national leader in the area of domestic violence, DSS should establish a unit of Substance Abuse Specialists to provide consultation to each local DSS Area Office and training to frontline workers.

Homelessness and Child Abuse

In Massachusetts **the number of homeless families increased by over 100 percent, to 10,000 families**, from 1990 to 1997. With an estimated two children per family, this means that **an estimated 20,000 children are homeless in our state**. Currently, Massachusetts ranks 24th highest in the number of children living at risk of homelessness.

According to the Worcester Family Research Project and The Better Homes Fund, homeless children are *hungry more than twice as often* as other children while two-thirds report they worry they won't have enough to eat. Homeless children are in *fair or poor health twice as often* as other children. Homeless newborns have *higher rates of low birth weight* and *need special care after birth four times as often* as other children.

Poverty, the rising cost of living, and lack of affordable housing are factors that push many families into homelessness. For others, however, histories of victimization and violence have played a role in making them and their children vulnerable to losing their homes. The intergenerational links among violence, child abuse, and homelessness are startling.

When violence from their childhood is combined with their experiences as adults, an incredible *92 percent of homeless mothers have been severely physically or sexually assaulted while 88 percent have been violently abused by a family member or intimate partner.* Nearly 25 percent of homeless children have witnessed these acts of violence within their families.

Homeless babies suffer from a significant slowing of their physical, cognitive and emotional development from the accumulated impact of severe environmental stresses under which they live. **Older homeless children struggle with very high rates of mental health problems.** Nearly one-third have at least one major mental disorder that interferes with their daily activities; nearly half have problems such as anxiety, depression or withdrawal; and over one-third manifest delinquent or aggressive behavior.

Sadly, at least **one-fifth of homeless children do not attend school.** For those who manage to attend, their physical and emotional status can make academic success difficult. Fourteen (14) percent of homeless children are diagnosed with learning disabilities, including dyslexia or speech and language problems. The Better Homes Fund reports that 36 percent of homeless children have repeated a grade while 14 percent were suspended from school. These effects of their academic and emotional problems occur at double the rate of other children.

Recommendations

The **State Call To Action** proposes funding for shelters to hire trauma specialists who can identify women and children with histories of violence, provide a range of support and psycho-educational groups and when, necessary, family therapy and counseling for children. Programs serving homeless children should include training to sensitize workers to the issues of domestic violence, child abuse and trauma.

Hiring experienced case managers is also critical for shelters so that comprehensive, integrated services can be coordinated across state and private agencies.

A range of family support services must be made available to homeless families including, newborn home visiting, parent aide services, and local family resource centers that can offer parents support and education. Creative solutions must be found to address the transportation needs of homeless families so that the health and educational status of their children are not further compromised.

Section III. ~ Protecting Our Children

To address systemic issues within the state's child protection network, the **Call To Action** proposes numerous recommendations. Key proposals include:

- **A multi-track system** to respond differentially to cases of child abuse and neglect depending on their degree of seriousness and risk to the child. Low risk DSS cases, cases "screened out" before or after investigation, and voluntary referrals from the community would be addressed through local Family Support collaboratives. This would allow the state's child protection agency to focus its resources more effectively on moderate to severe child abuse cases.
- **Quality child and family assessments** through a coordinated system of multidisciplinary teams with clearly delineated roles and functions to address the range of moderate to severe child abuse and neglect cases. Moderately serious cases would be assessed by Multidisciplinary Assessment Teams (MDATs) operating within the Department of Social Services. Severe cases and those requiring court involvement would be referred to a statewide network of Children's Advocacy Centers.
- Legislation to support a statewide system of **hospital-based Child Protection Teams** (CPT) within medical teaching institutions located regionally across the state. Each CPT would be trained to medically evaluate and treat children who have been abused and their families. Consultation available on a 24-hour basis to other hospitals in the region and to other rural medical sites would also be included.

A diagram of the **Proposed Multi-Track & Assessment Model** can be found in Chapter 7 (pages 76-77).

- A **statewide medical training program** to recruit, train and support pediatricians, nurses and other relevant medical providers to become child abuse and neglect specialists. A recent MCC survey confirmed the critical shortage of such medical experts. Despite Massachusetts' standing as one of the country's major hospital centers, fewer than ten recognized pediatric experts in child abuse could be identified across the state.
- A **plan to address workforce and case workload issues** within the state child protection agency. This would include: increasing the salaries of DSS workers to reflect the responsibility and risks of the job; establishing

legislation to adopt the Child Welfare League of America caseload standard; tapping into federal Title IV-E/B funding to develop graduate-level training for DSS staff; establishing staff reimbursements to support advanced training; creating a partnership between DSS and the Schools of Social Work to expand the pool of MSWs and BSWs for Child Protective Services; and developing the current DSS training program into a full-fledged Child Protective Services Institute.

- **Improvements in the state's foster care system**, including: reducing multiple placements of children in foster homes and residential settings; adequately funding and supporting relatives in caring for kin children; and expanding the availability of foster homes, particularly specialized homes able to meet the needs of traumatized children. Other recommendations include: identifying *young* adolescents likely to "age out" of foster care without adoption and providing them with early, permanent, and stable placements; ensuring the successful transition to independence for *older* adolescents "aging out" of foster care; and ensuring educational continuity for foster children.
- **Improvements in the state's adoption system**, including: involving children actively in the adoption process; implementing flexible and open adoption practices; researching alternative permanent placement options concurrent with other efforts to maintain children in their homes so that timely permanency and stability can be assured; considering kinship adoptions whenever appropriate; utilizing multidisciplinary teams as consultants when considering the termination of parental rights, during the adoption process and post-adoption period; expanding Massachusetts' successful permanency mediation program; mandating training for a broad range of professionals involved in termination and adoption proceedings; and providing needed post-adoption supports and treatment for traumatized children.
- Building **accountability in the child protection system** by expanding the role of the DSS Professional Advisory Committee (PAC) to include: the review of randomly selected cases and a public annual report to the Commissioner with recommendations for related policy and practice improvements; neutrality and independence of the PAC through the election of a non-DSS Chair and the convening of meetings within the community; the contracting with quality assurance professionals to apply professional methods of data gathering, to examine aggregated data, and conduct quality assurance. In regards to federally mandated Citizen Review Panels, the **Call To Action** proposes that annual reports of the panels' work and recommendations be published and made available to the legislature and the public. Further, it calls for oversight by the Executive Office of Health and Human Services to avoid redundancies, address gaps, and ensure uniform protocols for efficiency and quality assurance among the PAC, the recently established Citizen Review Boards, and the legislatively mandated Child Death Review Teams.
- **Improvements in court responses to abused and neglected children**, including: developing protocols for information sharing among the several Courts involved with children's cases; ensuring reporting of child abuse by the Courts; making available multidisciplinary child protection team

consultations to the Court; providing court-friendly practices for child victim witnesses; mandating judicial training in child protection; creating accountability within the state's Guardian Ad Litem (GAL) program; and providing legislative review of the Supreme Judicial Court's ruling in the cases of Jeremy and Issac.

Section IV. ~ Healing Our Children

To succeed in ending child maltreatment, child protective services, the legislature and the public-at-large must ensure that abused, neglected and traumatized children receive the appropriate treatment and supports they need to heal. Recommendations proposed by the **State Call To Action** include:

- **Treatment services for abused/neglected and traumatized children** that are responsive to their special needs for quality and flexibility. Specifics include: establishing an unprecedented state-level commitment that entitles every child victim of abuse, neglect or trauma in Massachusetts the full complement of therapeutic and other services needed to recover as fully as possible from the effects of their maltreatment; establishing a separate category for trauma-recovering children outside the current managed care capitation system so that limitations in the type, duration and frequency of clinical services can be waived for this special population.

  Other related treatment proposals call for: expanding the range of interventions for these children and providing adequate reimbursement for related evaluations and case coordination activities; piloting effective treatment and interventions based on new research findings on brain development and childhood trauma; establishing a Board of Education-sponsored scholarship and payback program for graduates in social service and mental health to address staff shortages in these fields; and the pooling of "blended" funding among state agencies to optimize services for children and to encourage inter-Departmental coordination and collaboration.

- **Schools as safe havens and healing places for abused, neglected and traumatized children.** Proposals include: training educators to identify the symptoms of traumatized children as a crucial starting point in developing a comprehensive school-wide approach to helping these children learn; creating clinical support systems for teachers to help them develop classroom strategies for addressing the needs of traumatized children; reevaluating school policies on confidentiality, curricula, and discipline in light of the needs of traumatized children; adapting the school curriculum to include interactive teaching styles and non-academic approaches that can foster development of self-confidence and mastery in traumatized children; and the development of protocols for early identification and services before children are at risk for discipline or school failure.

Section V. ~ Preventing The Hurt

The **State Call To Action** proposes the building of a strong infrastructure of family supports across the state that would work to address family needs *early on* so that state intervention would be avoided or reduced. It calls for:

- **Expansion of the DSS-administered "Community Connections" family support collaboratives statewide** and building its capacity to serve a broad range of voluntary referrals. Federal dollars have been the only source of support for these programs since 1993 and are only secure until 2002. Massachusetts must work *now* to ensure a smooth transition to state funding and expansion of this vital family support structure across the state.

- **Establishment of local Family Support Teams** to address low-risk child abuse cases within DSS, cases screened out by DSS before or after investigations, and voluntary referrals from the community. These Teams of local professionals and family advocates would coordinate family conferencing as a tool to assist families in assessing their own needs and the best ways to address them.

- **Collaboration among state and private family support and service providers,** coordinated through a specific state mandate backed with sufficient resources and quality assurance. One proposal put forth to accomplish this has been the creation of a Governor's Cabinet on Families and Children. The Cabinet would coordinate planning and services of the various state agencies involved with children and families, coordinate state efforts at the local level, and address identified gaps in service coverage. The Cabinet would endorse and actively promote the principles of family support, and would coordinate training in family support practices among state and private service providers.

- **Funding for universal, newborn home visiting** for all new parents seeking this support. Massachusetts can be proud of its success in making available newborn home visitation support to all parents 20 and under. The state must now move to benchmark when and how it will phase in universal home visitation for all new parents, irrespective of parental age.

- **Expansion of family support services** that have documented their effectiveness in preventing child abuse and neglect and in reducing the stresses associated with child maltreatment. Programs, including the self-help Parents Helping Parents, the Family Nurturing Program, and parent aides must be expanded where they currently exist and their availability extended statewide.

- **Expansion of Shaken Baby Syndrome (SBS) prevention efforts.** Massachusetts should replicate efforts that have succeeded in reducing SBS-related infant death and disability. Initiatives aimed at educating new parents within birthing hospitals, and special outreach to young men - the most frequent perpetrators of SBS - should be implemented. All state agencies involved with parents and children should incorporate SBS prevention education into their training and direct service programs.

- **Development of a comprehensive, coordinated, statewide strategy to effectively reduce sexual assaults against children** and to address the critical lack of effective evaluation and treatment resources for both child victims and for child, youth, and adult offenders. Public education efforts involving the media should be an integral part of the strategy. Such coordinated efforts in Vermont have reduced confirmed cases by over 50 percent over a decade. Massachusetts should set a similar goal and work to achieve it.

Section VI. ~ Taking Action

Research suggests that without intervention and supports many abused and neglected children can become society's most disabled, dysfunctional and dependent individuals. Increasingly, **child maltreatment appears to be the common denominator underlying our most serious social problems** - from delinquency and runaway behavior in adolescents to the violence and sexual crimes of adults. For example, *over 50 percent of juvenile offenders served by the Department of Youth Services have previously been abused or neglected children and under the care of DSS.* A 1998 Boston University study concludes that children who are abused and neglected are *1.8 times more likely* to be arrested as juveniles, and *1.5 times more likely* to be arrested as adults, than children who have not been exposed to abuse or neglect.

The human and social costs of abuse translate into enormous fiscal costs for society. Estimated expenses for dealing with the aftermath of violence against children range from a conservative $30 billion dollars annually, according to researcher van der Kolk, to $56 billion dollars estimated by the National Institute of Justice in 1996. After abuse and neglect have occurred, we pay for emergency medical care, investigation, foster placement of child victims, emergency shelters, therapeutic, rehabilitative and special education services, and emergency shelters. In the long term, the costs of juvenile detention, adult institutionalization, and incarceration are added to the bill.

The high costs of adult medical care related to the long-term consequences of child abuse and neglect can now also be included. A new study conducted by the U.S. Centers for Disease Control and Prevention and other leading research groups confirms: *the extent of exposure to physical, emotional, sexual abuse, and household dysfunction in childhood has a significant graded relationship to multiple risk factors for the leading causes of deaths in adults* – including, ischemic heart disease, cancer, chronic lung disease and liver disease.

In working to reduce these staggering human and fiscal tolls, an unprecedented commitment must be made to **ensure effective treatment services** for abused/neglected children and their families *as soon as they are identified.* It must be matched with a parallel commitment to **strengthen state systems** charged with the care and protection of these children and to **expand family support and prevention services significantly**, to keep families from failing and children from being damaged *in the first place.*

These efforts must not be viewed as separate and competing. They are inextricably bound to each other and are fundamentally tied to our success in ending the tragic abuse and neglect of our children's minds, bodies and spirits.

Next Steps

With publication of the **State Call To Action**, the Summit Initiative moves to its next phase. During 2001 and beyond, MCC and its Summit colleagues will work to engage an even larger constituency to support implementation of the proposed agenda. Targets of our dissemination, education, and mobilization efforts will include: community leaders, legislators, government officials, faith-based groups, business representatives, and the public, including citizen members of MCC's Campaign For Children, and adults who have been affected by abuse and neglect.

In the months ahead, MCC will convene new Summit Work Groups to document the costs to implement proposed recommendations, target appropriate revenue streams, and develop strategies to create new sources of funding. We will work with legislative leaders and our colleagues to draft child protection and family support legislation. In collaboration with our prevention partners, we will work to develop a statewide strategy to reduce child sexual abuse and to ensure quality care for its victims.

During the period leading up to the 2002 Massachusetts State elections, MCC will educate candidates about the **Call To Action** and work to secure their endorsement of its recommendations. Through candidate briefings, published results of candidate questionnaires and public opinion polling, we will provide citizens with information so they themselves can decide when choosing their elected officials, "Who's for kids, and who's just kidding?"

Working in collaboration with our Summit partners, MCC will continue providing leadership for the broad-based effort to end the abuse and neglect of Massachusetts' children.

SECTION I

Incidence and Impact of Abuse and Neglect on Children

We are living through the greatest times in history in terms of material prosperity, but it will be a commentary on our times and our individual and collective lives if we do nothing about these horrors known as child abuse. Here, in the greatest country in the world, I ask you - How can we honestly proclaim ourselves the stewards of our time if we allow this to go on?

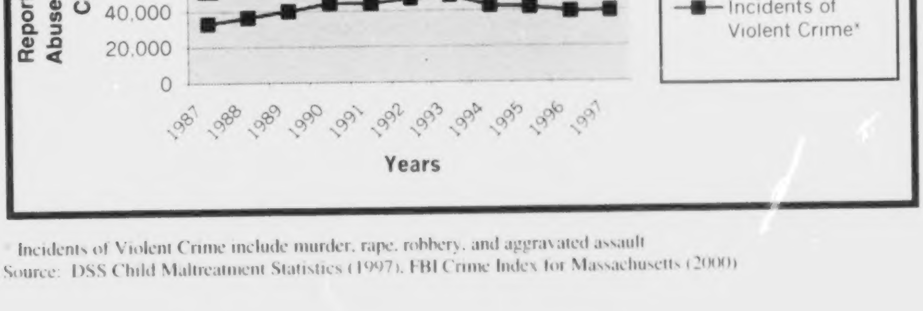
Tom Brokaw, News Commentator

CHAPTER 1

Incidence and Prevalence

Over the ten-year period from 1987 to 1997, **Massachusetts saw a 98 percent increase in the number of children reported for abuse or neglect.** This is in contrast to an increase of 54 percent nationally during the same period. Based on Massachusetts' child population of 1.5 million[9] in 1997 and the number of reported children that year, we see that **roughly 46 of every 1,000 children was involved in a child abuse report**.[10]

Although child abuse statistics for 1998 showed a reduction of 2,000 reports from the previous year, state officials believe the transition into new data systems may have accounted for the slight decrease. Recently released 1999 statistics confirm a persistent and ever worsening problem, even while the state's violent crime rate decreased 21 percent from 1993 to 1998.[11]



* Incidents of Violent Crime include murder, rape, robbery, and aggravated assault
Source: DSS Child Maltreatment Statistics (1997), FBI Crime Index for Massachusetts (2000)

National reporting figures provide some picture of how many children are identified as abused each year, an estimated 3.1 million reported in 1998,[12] but they do not indicate the cumulative total of children who are maltreated at some time during their childhoods. Attempting to estimate the total prevalence rate from the yearly incidence figures is confounded by a number of factors, including differences in the incidence of abuse among different age and socio-economic groups, and the likelihood that victims of long-term abuse are identified repeatedly through child abuse reporting.[13]

Underreporting is also a significant factor that prevents accurate quantification of the prevalence of child abuse. For example, one study indicates that 84 percent of children who are sexually abused never report the abuse.[14]

The "Adverse Childhood Experiences Study"[15] recently completed by Dr. Vincent Felitti of Kaiser Permanente and several noted research groups including, the U.S. Centers for Disease Control and Prevention and the National Center for Chronic Disease Prevention and Health Promotion, gives us a startling picture of the pervasiveness of child abuse.

A questionnaire was mailed to over 13,000 adults who had completed a standardized medical evaluation at Kaiser Permanente, a large HMO. Over 70 percent responded to inquiries about seven categories of adverse childhood experiences including: living with household members who were substance abusers, witnessing violence, or experiencing physical, emotional, or sexual abuse as a child. While substance abuse in the household was the most prevalent exposure of the seven categories described, *more than half of the respondents experienced more than one or equal to four categories of abuse.*

Who Are These Children?

Boys and girls are neglected, physically abused, and emotionally maltreated in approximately equal numbers.[16] Reports of sexual abuse generally involve girls. The lower reporting rate for boys is thought to be a result of less disclosure. The recent organizing of support groups among adult men who were child victims of sexual abuse makes it clear that underreporting is a main factor, particularly underreporting of sexual abuse of boys by their mothers and other female caretakers.[17]

Children from every city and town in Massachusetts and from every social and economic group are suffering from abuse or neglect. Some communities, however, have higher reporting rates accompanied by similar high rates of domestic violence, poverty, homelessness, and substance abuse.

The following are cities and towns with the highest and lowest reporting rates in 1997.[18] The rate is based on the number of reported children per 1,000 resident children under the age of eighteen and includes only those cities or towns in Massachusetts that had 275 or more children in residence who were reported for maltreatment. (For the reporting rates of other Massachusetts cities and towns, see Appendix C.)

12 Cities/Towns with the Highest Number of Children Reported 1997

Holyoke
Greenfield
North Adams
Lynn
Brockton
Lawrence
Pittsfield
Chelsea
Fall River
New Bedford
Chicopee
Fitchburg

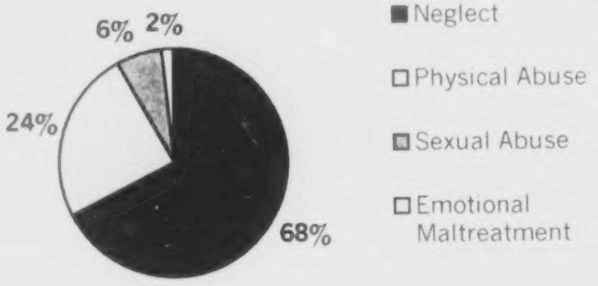
12 Cities/Towns with the Lowest Number of Children Reported 1997

Waltham
Weymouth
Woburn
Peabody
Attleboro
Quincy
Medford
Methuen
Leominster
Cambridge
Marlborough
Plymouth

Neglect was the most common type of maltreatment in Massachusetts in 1997, totaling about 68% of substantiated cases, followed by physical abuse at 24%. Cases involving emotional maltreatment as the prime concern comprised 2% of the cases. Substantiated sexual abuse cases (6%) in Massachusetts were less than half the national average (15%)[19] but still represented far too many violated children.[20]

The following represents substantiated cases in Massachusetts in 1997:

Types of Abuse Inflicted on Children in Massachusetts (1997)



Source: DSS Child Maltreatment Statistics (1997)

Neglect

In 1997, almost 70% of reports to child protective services in Massachusetts were because of neglect or deprivation of necessities.

Child neglect is a complex and multi-faceted type of maltreatment. It can be fatal or it can slowly and almost invisibly undermine a child's cognitive and psychological development until the child has little ability to bond with others.[21] Sometimes neglect is defined as the failure of a parent or caretaker to provide a child with needed care and protection, e.g. proper food, clothing, shelter, or supervision. Other definitions focus on the condition of the child, regardless of the specific cause or intent of the parent or caretaker. For example, educational neglect affects children who are truant chronically, oftentimes because of a need to care for younger siblings or because of the emotional or substance abuse problems their parents face.

The impact of neglect can be devastating, particularly since it affects disproportionately infants and preschoolers who are at their most vulnerable developmental stage. The short-term effect is often the increased exposure of children to dangerous or life-threatening conditions. Some infants are "failure to thrive" victims, their physical and developmental growth arrested, sometimes fatally. Irreversible brain damage can be caused by lack of parental affection and stimulation in the first years of life. Studies have concluded that 40 percent of child fatalities due to child maltreatment are the result of neglect.[22]

A review of recent studies by the National Center on Child Abuse Prevention Research at Prevent Child Abuse America confirms that the long-term effects of neglect can result in serious and lasting cognitive and emotion harm to children of a young age, and an increased rate of delinquency, drug and alcohol abuse, and teenage pregnancy as they grow older.[23]

Physical Abuse

One-quarter of the children reported to DSS are victims of physical abuse. Physical abuse can include a range of injuries including: bruises and welts from being hit with hands, fists, or objects such as straps, wooden boards, wire hangers. Broken bones and fractures, organ damage from being punched, kicked or thrown, and burns from cigarettes, irons, and from immersion in scalding water, constitute the types of abuse that can cause serious or fatal injury.

Brain injury is reported in nearly 44 percent of all cases of reported physical abuse. According to the American Academy of Pediatrics Committee on Child Abuse and Neglect, child abuse is the source of 95 percent of serious head injuries in infants less than 1 year of age, and accounts for up to 80 percent of deaths from head traumas in infants less than 2 years of age.[24]

A major form of physical violence contributing to brain injury among infants and young children is Shaken Baby (or Infant) Syndrome (SBS). Children under two can easily be injured from shaking because their weak neck muscles are not yet strong enough to fully control their head movements. When a child is shaken, the head whips back and forth slamming the fragile brain tissue against the hard skull, causing bruising, bleeding, and swelling inside the brain. When the shaking is combined with throwing an infant or child against a mattress or hard surface, the instant deceleration applies more force to the brain and more damage can occur.

In addition to brain and retinal injuries associated with SBS, a Philadelphia study conducted by prominent researchers Duhaime, Gennarelli, and Thibault documented frequent skull fractures among fatal cases of infant abuse, suggesting that these children are also struck with objects or thrown against them with significant force.[25] As a result, Duhaime and colleagues have suggested referring to this syndrome as Shaken Impact Syndrome.

Depending on the age of the child and how severe the shaking or impact, injuries can include: learning disabilities, delays in development, speech problems, impaired use of arms and legs, brain damage and seizures, hearing loss, partial or total blindness, spinal injury, paralysis, and mental retardation. According to Dr. Jacy Showers, a prominent expert in the field, it is estimated that up to one-third of children who are victims of SBS die from their injuries while 50 percent sustain severe lifelong neurological problems.[26]

Sexual Abuse

Sexual abuse of a child is defined as inappropriately subjecting or exposing a child to sexual contact, activity, or behavior. Non-touching sexual offenses include indecent exposure or exhibitionism, exposing children to pornographic material, deliberately exposing a child to the act of sexual intercourse and/or masturbation in front of a child. Touching offenses include sexual fondling, making a child touch an adult's sexual organs, forcing a child to engage in sexual intercourse or activity. Sexual exploitation of children can include engaging a child for the purposes of prostitution or using a child to film or model pornography.

Nationwide, reports of child sexual abuse declined from an estimated 425,000 in 1991 to an estimated 223,000 in 1997.[27] In considering any declines, it is important to remember that only a subset of child sexual abuse cases are actually identified or reported to child protective services each year.[28] Researchers estimate that as many as 85 percent of child sexual abuse cases are never reported to authorities.

Retrospective surveys are now supporting the estimate that at least 20 percent, and possibly higher, of all American women and 5 percent to 16 percent of American men experience some form of sexual abuse as children.[29] If the number of sexually abused children today is as great as the number of adults who claim to have been child victims, we can then conclude that *less than one-third of sexually abused children are being currently identified and reported.*

Declines in reports may be completely or partly due to factors that are not related to the actual incidence of sexual abuse. For example, "child abuse backlash" reported by some researchers may play a role.[30] The dominant and incorrect message to the public has often been that false allegations are frequent and that innocent people are unfairly stigmatized. As a result, media coverage of child sexual abuse cases may be fueling a more skeptical attitude toward the problem than in the past and causing the public and professionals to be more reluctant to report such cases. Legislative initiatives to increase the rights of alleged perpetrators have also taken hold in certain states and, as a result, victims may be more reluctant to seek help.

A number of other factors may account for the decrease in investigations and substantiation of cases after they are reported.[41] For example:

- The required level of evidence is not possible to meet because the child victim is too young to communicate, or the abuser is also a child.
- Child protective services may be excluding cases of extra-familial child sexual abuse and redefining their definition of "caretaker" to exclude non-immediate family members. These cases may be referred directly to the police, eliminating child protective services' involvement.
- Cases involving adolescent victims or offenders may also be referred to the police.
- More stringent screening practices by child protective service workers may be turning away less serious cases and raising the threshold for cases needing investigation.
- State investigators may be more conservative in the criteria they use to substantiate cases because they fear entanglement in an appeals process, particularly when able counsel represent alleged offenders.
- Structured risk-assessment protocols may be substituting clinical judgments about whether or not the abuse should be substantiated. Such protocols could result in accurate judgments. However, if they are based solely on meeting legal burdens of proof, more children are likely to remain in dangerous situations.

A review of national incidence studies by researcher David Finkelhor found that girls are sexually abused three times more often than boys.[42] Despite the public's perception that highly publicized cases of sexual assaults by teachers, clergymen and other unrelated adults are the norm, they make up less than 10 percent of sexual assaults against children. According to child abuse researchers, *in 90 percent of child sexual abuse cases, the child knows and trusts the person who commits the abuse.* Most sexual abusers are fathers, mothers, stepparents, grandparents and other family members or adults who have close contact with the child.[43]

Sexual abuse exists in low, middle, and high-income families across the state. There are no markers to help us identify when sexual abuse is more likely to occur. However, some studies show that the most important indicator of risk for sexual abuse is the compromised ability of a parent to provide adequate supervision to their child, e.g. marital conflicts, unavailability, substance abuse. The factors that reduce appropriate parental supervision can also produce emotionally vulnerable children who in turn can fall prey more easily to sexual abusers offering affection, attention, and friendship.[44]

The effects of sexual abuse on children can be devastating and long-term, especially when timely and effective treatment is not available. A variety of studies show that sexually abused children can experience a chronic self-perception of helplessness, hopelessness, depression, impaired trust, self-blame, self-destructive behavior, and low self-esteem.[35] Anger and emotional distress are also cited, as well as alcohol and drug dependency when the child reaches adolescence or adulthood.[36]

Emotional Abuse

In 1997, emotional maltreatment was the presenting problem in 2 percent of the reports made to DSS. While clinical descriptions of child abuse and neglect suggest psychological harm from other forms of maltreatment, practitioners and researchers still struggle to clearly define the nature and consequences of emotional abuse.

A study conducted by noted researchers Garbarino, Guttman, and Seeley in 1987 suggests a pattern of psychologically destructive behavior that constitutes a concerted attack on the child's development of self and social competence.[37] Included are behaviors that reject, isolate, terrorize, ignore, and corrupt the normal development of the child.

Consequences for child victims are devastating. Infants can show non-organic failure to thrive, anxiety, and inadequate social responses. Older children can show signs of feeling unloved, inferior, and negative in their view of the world and themselves. They may show symptoms of fear, anxiety, and aggression. Internalized, these feelings may provoke self-destructive, depressed, withdrawn or even suicidal behavior. Externalized, they can lead to aggressive, impulsive, and violent behaviors.

Emotional maltreatment of children remains one of the least reported and potentially devastating forms of abuse.[38]

CHAPTER 2

Impact of Abuse and Neglect on Child Development

For some children, the effects of abuse, neglect, and witnessing violence can be buffered by close personal relationships they form with trusted adults. Social supports can even help them recover from such traumatic events, particularly when current attachments to safety figures outweigh the terrors of the past, according to trauma researcher Dr. Bessel van der Kolk.[39]

For too many children, however, these experiences result in scars that, if not indelible, are exceedingly difficult to erase. This is particularly true when abuse, neglect, or trauma from violence occurs by age three.[40] Experts say that traumatic early experiences can cause a normal child to become developmentally delayed or develop serious emotional problems. Research has established that early childhood trauma has a profound impact on the emotional, behavioral, cognitive, social, and physical functioning of children.[41]

A 1995 Baylor University study found that children who were rarely touched or spoken to and who were not allowed to explore and experiment with toys developed brains that were 20 to 30 percent smaller than normal for children their age.[42] The study conducted by Dr. Bruce Perry also found that, "multiply abused infants and toddlers often experience developmental delays across a broad spectrum, including cognitive, language, motor, and socialization skills."[43]

In a sample of sexually abused children,[44] victimized children were found to display the following symptoms and behaviors:

- 61% exhibited anxiety symptoms
- 41% depressive symptoms
- 31% regressive behaviors
- 36% inappropriate sexual behaviors

Other symptoms, such as eating disorders, have also been found to relate to child physical and/or sexual abuse.[45] In addition, maltreated children have been found to develop a variety of psychiatric conditions, including Attention Deficit and Hyperactive Disorder (ADHD), Oppositional Defiant Disorder, Conduct Disorder, Separation Anxiety/Overanxious, Phobias, and Posttraumatic Stress Disorder (PTSD).[46]

Impact of Abuse and Neglect on Early Brain Development

The human brain is not fully developed at birth and represents only 25 percent of its approximate weight at adulthood. It depends upon individual experiences to guide its growth and development. Experiences and sensory inputs organize the brain's patterns of communication between neurons and determine how we think, feel, and behave.[47]

As the brain develops, it begins to organize and eliminate unnecessary, rarely used neural connections.[48] Connections that are used repeatedly during the early years of a child's life become the life-long foundation of the brain's organization and function.[49] By three years old, a child's brain has reached approximately 90 percent of its full potential. To reach this optimal stage, the brain requires good health and nutrition, as well as a great deal of stimulation and support.[50]

Thus, a loving, secure, stimulating environment fosters healthy development, while a continually neglectful, physically or emotionally abusive environment can create significant, long-term harm.[51] The quality of a child's earliest experiences, including the quality of infant and toddler childcare, plays a crucial role in the overall development of the brain.[52]

Early trauma alters the development of the brain. Failure to properly nourish a child, inflicting physical pain and injury or simply ignoring the emotional needs of a small child can cause trauma. Damage can be significantly more detrimental than other diseases that affect the brain and can often be corrected through drugs or surgery. Influencing the way the brain functions in repeatedly harmful ways can result in permanent and irreversible injury.[53 54]

The neural connections established during the early years of life respond to certain patterns. Traumatic experiences, for example, when a child endures physical or sexual abuse, or witnesses violence, can increase the production of cortisol, a brain hormone that can lead to a destruction of neurons and a reduction in synapse formation, thus altering brain function. Chemical levels in the brain and blood play a role in determining how a person will respond to challenges in the environment. When a child lives in constant fear or has experienced trauma, they live in a state of chronic stress. Research has found that children with chronically high levels of cortisol demonstrate more cognitive, motor, and social delays than other children.[55]

Serotonin and noradrenaline also play significant roles in brain function. Serotonin modulates emotions, including aggression, while noradrenaline regulates responses to fear and anger. Under normal circumstances, these hormones work harmoniously. However, traumatic events and/or chronic stresses can alter levels of these hormones, resulting in a variety of emotional, behavioral, and cognitive problems.

Children who are physically abused in early life develop brains that are highly attuned to aggression and danger. It has been found that, "early, frequent, and intense stress tunes the brain to set stress regulation mechanisms at high levels."[56] As a result, the child often lives life in a perpetual state of fear. A child of this type may behave more aggressively to environmental stress and may have difficulty controlling his or her aggressive actions.

Similar to adult veterans of war, children exposed to trauma may experience symptoms of Posttraumatic Stress Disorder (PTSD). PTSD is a syndrome that occurs in response to a highly distressing event. After the occurrence of a traumatic event, the child frequently re-experiences the event through nightmares or intrusive thoughts. As a result of the stress on the child, symptoms such as jumpiness, sleep disturbance, and poor concentration undermine his or her stability.

Immediate and Long Term Behavioral Effects of Abuse and Neglect

Several immediate responses to child abuse trauma have been identified in children. Many show difficulty remaining calm when faced with emotional challenges, and develop what are termed "arousal disorders." Others have the tendency to overreact or freeze in uncomfortable situations. Children may also experience attention difficulties that make it hard to focus on and complete tasks.[57] Other physiological responses include increased heart rate, temperature, and blood pressure. Many children also continuously scan their environment for danger and over-interpret the actions of others.[58]

Traumatic experiences in childhood increase the risk of developing future psychiatric symptoms in adolescence and adulthood.[59] Depending on the frequency, nature, severity, and pattern of traumatic experiences, at least half of all exposed children are at risk of developing considerable neuropsychiatric conditions.[60] Most researchers agree that the difficulties of abused and neglected children intensify over time, particularly when abuse is longstanding and no formal intervention occurs.[61]

Some of the long-term problems experienced by children who have been traumatized include difficulties forming and maintaining stable relationships with others, as well as problems meeting their own personal needs. Affected brain development, especially at an early age, can have long-term effects on cognition, the regulation of emotions, and social interactions. Problems that abused and neglected children face as they grow into adulthood can include:

- Increased prevalence of drug or alcohol dependence
- Increased rate of status offenses - running away, truancy
- Delinquent behavior and adult criminal behavior
- Growing up to repeat abusive and neglectful parenting behaviors
- Lost future earnings

- Recurring health problems - physical and mental

The "Adverse Childhood Experiences Study" described in Chapter 1 has also documented the link between abuse in childhood and risk factors for adult disease. The U.S. Centers for Disease Control and Prevention, joined by other leading health researchers, confirm: *there is a significant graded relationship between the extent of exposure to emotional, physical, sexual abuse and household dysfunction during childhood and multiple risk factors for the leading causes of deaths in adults - including, ischemic heart disease, cancer, chronic lung disease and liver disease.*[62]

A study completed in 1983, following up on 97 boys who in 1943 had been abused and neglected, found that 45 percent had become criminals, alcoholics, mentally ill, or had died before the age of 35.[63] According to researcher Widom, being abused and neglected as a child can increase the likelihood of arrest as a juvenile by 53 percent, and arrest as an adult for violent crime by 38 percent.[64]

Most tragically, if the cycle of violence is not interrupted, child abuse and family violence can be perpetuated for generations. Parents that abuse their own children, and the victims and perpetrators of other forms of domestic violence, are frequently survivors of maltreatment in their own childhoods.[65]

Trauma and Learning

Maltreated children have greater behavioral problems and perform significantly worse in school, according to a study by Dr. van der Kolk:

- 30% of abused children have some form of language or cognitive disability;
- 50% or more have difficulty in school, including poor attendance and misconduct;
- 22% or more have a learning disorder;
- 25% require special education services at some time.[66]

Significant differences in academic performance are also found between maltreated and non-maltreated groups of children.[67] The constant threats experienced by an abused child can result in the child being fearful and over-vigilant, even in situations that present no risks. Concentrating on the emotional and physical cues of other people, including teachers, the abused child may have difficulty taking in academic information and may fail to develop appropriate problem-solving and language skills. In one study, the cortex, or thinking part of the brain, was 20 percent smaller on average in abused children than in those children who had not been victimized.[68]

Resiliency and Early Intervention

Resiliency can be defined as "strength under adversity." It is the capacity to withstand the effects of adverse conditions. According to childhood trauma expert Mark Katz, PhD, "There is a myth that children are resilient. If anything, we now know that children are more vulnerable to trauma than adults."

The brain's agility provides potential for positive experiences to lessen the damage of trauma.[69] These protective influences can be found in families, communities and schools, but too often they are lacking.[70] For example, it is not uncommon to hear of children who are berated or punished in school for poor concentration and aggressive behavior that are themselves the results of previous trauma and violence. In such instances, the school fails to be a supportive environment and a protective influence, and becomes yet another traumatizing influence on already vulnerable children.

It is important to note that resiliency decreases, as children get older. Increased exposure to risk and the severity of risk also decreases resiliency. This demonstrates the critical need for early intervention in the lives of abused or neglected children in order to minimize these damaging effects.

SECTION II

Key Causes and Links

> *I have looked into the eyes of so many children and seen the devastating effects of abuse and neglect…many adults who have abused their children…were once abused themselves and can't find a way out of that vicious cycle. So many of you who are committed to this issue understand clearly that prevention…is the most important commitment we can make.*
>
> **First Lady Hillary Rodham Clinton**
> Washington, D.C., October 1998

CHAPTER 3

Children Living in Homes With Domestic Violence

Estimates are that between 3.1 and 10 million children witness acts of domestic violence each year.[71,72] Currently, about **43,000 children in Massachusetts are exposed to domestic violence annually, and an even greater number of cases are unreported**.[73] In a 1994 report, the Department of Social Services reported that an average of 32 percent of its cases involved domestic violence. Five years later it revised its figures upward to 40 to 60 percent, or 22,000 of its open protective cases.

Research indicates that 30 to 60 percent of children from homes where domestic violence is present are also victims of abuse themselves.[74] In a 1995 national survey of over 6,000 American families, Strauss and Gelles[75] found that **50 percent of the men who assaulted their wives also frequently physically abused their children**. In Massachusetts, a 1991 Boston City Hospital study found 59% of mothers of abused and neglected children had medical records suggesting they were victims of domestic violence.[76]

Co-occurrence of Child Abuse and Domestic Violence

Independent of one another, child abuse and domestic violence can endanger children, impair development and lead to long-term negative outcomes.[77] The co-occurrence of domestic violence and child abuse, however, can compound even further the negative effects children are likely to experience over their lifetime.[78]

The health risks for children of parents engaged in domestic violence can begin even before birth. Estimates are that as many as 20 percent of pregnant women experience personal violence.[79] The direct trauma or stress of abuse during pregnancy can lead to low birth weight, premature birth, fetal distress, fetal injury, and death.[80]

Children's physical, emotional, behavioral and psychological development can be impacted on both a short and long-term basis. Mothers who are stressed and burdened by being victimized are also at an increased risk of neglectful parenting.[81] Mothers experiencing abuse may also be less available to provide care and emotional support to their children.[82]

Long-term consequences to children can include higher rates of mental illness, drug abuse, and criminal justice involvement as an adult. Children exposed to domestic violence are at greater risk for sexual abuse outside the home, as well. In fact, their risk of sexual abuse is seven times greater than for children not exposed to domestic violence.[83] Most distressing is that *domestic violence constitutes the "single, major precursor" for child maltreatment fatalities.*[84]

Children growing up in abusive homes are also at risk of developing violent behaviors, and repeating the cycle to become abusers themselves. **Of children that witness domestic violence, it is estimated that 30 percent later become perpetrators of violence**, as compared to a rate of 2 to 4 percent in the general population.[85]

Children suffer through both the trauma of experiencing violence, as well as the horrors of witnessing violence against a loved one. Researchers now know that children who see or hear a parent being battered can experience the same level of trauma as children who themselves are beaten. In one study, 93 percent of children witnessing domestic violence were diagnosed with Posttraumatic Stress Disorder (PTSD).[86]

Despite the growing research pointing to the devastating emotional effects on children of witnessing violence, the controversy over whether to screen these cases in for protective custody on the grounds of emotional abuse is still not resolved. In an attempt to address this issue in Massachusetts, the current Governor's Commission on Domestic Violence is reviewing DSS protective intake policy. Although universal screening for domestic violence is warranted, it is extremely difficult to ascertain which cases require child protection intervention that might lead to emergency shelter care and court involvement, and which cases would be better served through a referral to community supports and treatment.

Mothers often fail to seek help because they fear a referral to DSS will be made and that their children will be removed if they choose not to leave their abusive spouse or partner. Further compounding their dilemma is the fact that the "clinical and legal mind-set" in Massachusetts has not shifted sufficiently towards holding batterers accountable.[87] Many battered women report that batterers repeatedly violate orders of protection, or gain access to severely traumatized children through court-ordered evaluations that reflect bias against the protective parent or ignore the clinical needs of the child.

Integrating Child Welfare and Domestic Violence in Massachusetts

Few public policies nationwide have provided guidance on how child welfare and domestic violence organizations can best address these issues when they co-occur in families. Yet collaborative responses between these fields appear to be the best way to keep mothers with their children while keeping children safe.

The Massachusetts Department of Social Services was the first public child welfare agency in the country to initiate programs to address both child abuse and domestic violence. It began in the late 1980s, initiating programs to assist DSS in helping mothers to seek safety and support for themselves and their children.[ss]

Battered women's shelters that received a majority of their funding from DSS began to complain that DSS was victimizing children by removing children from mothers and forcing them to seek restraining orders. DSS workers argued that programs for battered women were overlooking the needs of children witnessing or experiencing violence at the hands of an abuser.

In 1990, as a first step toward addressing some of these concerns, DSS moved to integrate battered women's advocates into the child welfare setting. A pilot program with two sites (one urban and one rural) was developed. Utilizing a multidisciplinary approach, the pilots sought to coordinate child welfare and domestic violence practice by examining the impact of domestic violence throughout the life of the DSS case. The pilot sites received specialized trainings in safety planning, risk assessment, intervention and treatment. Funds were also awarded to these sites to provide intervention programs for batterers.

Two years after this successful pilot was launched, it became evident to women's advocates that the philosophy underlying their work could become an integral part of child welfare practice if enough time, training, staff support, and resources were provided to DSS staff and their clients.

In 1994, DSS harnessed the support of the Massachusetts Coalition for Battered Women's Service Groups and secured legislative funding to expand their domestic violence program. The current Domestic Violence Program at DSS includes a continuum of care including: services for battered women and their children, coordination, batterer intervention, emergency response, and prevention. In addition, training in domestic violence is now agency-wide.

One of the most effective components of the DSS Domestic Violence Program is the role of its 14 Domestic Violence Specialists. Each Specialist covers two to three local DSS Area Offices. Their duties include individual case consultation with direct line workers, sharing information on available services, and direct advocacy for women and children.

One of their primary goals is to educate and support DSS staff. Since the area of domestic violence is a complex and evolving one, caseworkers constrained by high caseloads and emergencies cannot be expected to keep abreast of rapidly changing developments in the field. The Specialists can provide that expertise. Also, working with domestic violence cases can pose risks for social workers. The Specialist is an important resource in assisting the social worker to develop her own safety plan and address her concerns about safety for all involved in the case. Specialists also participate in DSS multidisciplinary teams, providing insight at the assessment level, and proposing effective interventions in cases in which child abuse and domestic violence co-occur.

Other noteworthy initiatives within the Domestic Violence Program include:

> *Shelters for Substance Abusing Battered Women*
>
> These shelters provide comprehensive services to substance abusing battered women and their children for six months, with follow-up services for up to one year. The programs work with DSS to reunify mothers with their children when appropriate.
>
> *Visitation Centers*
>
> Currently, 16 Visitation Centers are located throughout the state to provide safe and supervised visitation services to children and families that have separated due to domestic violence. The Centers also serve as neutral pick-up and drop-off points when supervision of visits is not mandated.
>
> *Specialized Clinical Assessment*
>
> Traditional clinical assessments have not adequately addressed the presence of partner abuse in the home and the effects of witnessing violence on children. Children's Charter, a private organization, works with DSS to provide evaluation and ongoing clinical services to families where children have witnessed violence.

DSS also funds 35 battered women's programs across the state to provide shelter, intervention, support, advocacy and transitional living services to battered women and their children. A statewide telecommunications network links these programs so that data and immediate information on bed availability can be provided.

RECOMMENDATIONS

1. **Address local DSS Area Office gaps in assessments, services and advocacy in cases where child abuse and domestic violence co-occur.**

   The success of the Massachusetts domestic violence and child welfare model was the result of strong DSS Central Office leadership and the commitment and support of battered women's programs, communities, and local DSS direct service staff who have worked effectively with Domestic Violence Specialists. Though a 1997 study showed that 62 percent of DSS Supervisors had consulted a domestic violence specialist five times or more,[89] the commitment to this casework resource today is still not uniform across the DSS system. DSS Area Office Directors and Program Managers must be further exposed to the benefits and success of this model so that children and families in every part of the state can take advantage of better assessments, services, and advocacy when abuse and domestic violence occur in their lives.

2. Increase the number of Domestic Violence Specialists.

In the first three months of 1998, Specialists provided 1,519 consultations involving 1,210 families, of which 670 were new families.[90] These numbers demonstrate the widespread need for Domestic Violence Specialists in current DSS practice. Currently, Specialists balance their time among two or three Area Offices that are often 50 miles apart. In addition to providing individual case consultation and advocacy, Specialists network with community agencies and also provide them with critical training and technical assistance. These activities are creating a well-trained and coordinated network of community services to meet the needs of battered women and their children. They must be more widely supported.

3. Expand specialized treatment for child victims of domestic violence.

Some child victims who witness violence require specialized treatment. The state is making some progress in developing new interventions in this area. For example, special DSS funds help support the Children's Charter in Waltham and the Child Witness to Violence Program at Boston Medical Center where new approaches are being developed to help these vulnerable children. These efforts, however, are still in the developing stage, and providers say there is an "overwhelming" shortage of specialized care. Overall, the scarcity of qualified counselors and personnel is striking in view of the reported increases in family violence.[91]

4. Expand training about domestic violence for child welfare providers, school personnel, providers of medical care for women and children, and juvenile, family and criminal court personnel.

In order to identify mothers and children being victimized by domestic abuse, providers of care to children and families need to be trained to identify signs of this problem. Training must include the dynamics of family violence and the significant impact witnessing violence has on the child. Knowledge of effective and culturally responsive interventions, including safety planning, is crucial. Training should be provided within state, as well as private, non-profit agencies that work with women and children so that the response to children living with domestic violence is consistent and universal.

5. Address gaps in services for victims of domestic violence at the community level.

The child protection system sees the most serious cases of domestic violence. However, many other women and children who require assistance have not been referred to the child protection agency. As a result, community-based responses are necessary to address the needs of battered women and their children *regardless of the point of referral*. Family support programs can assist victims and their children by providing transportation, respite, childcare, and other services. These programs can also focus on family violence prevention. Community-based justice programs can offer neighborhood crime watches, ensuring that restraining orders against batterers are enforced and that batterer accountability remains a priority. These programs can provide a continuum of services and prevention responses for the population of domestic violence victims and their children who are not served by the child protection agency.

CHAPTER 4

Children Living With Parental Alcohol and Substance Abuse

There are 28 million children of alcoholics and several million children of drug addicts and abusers in the United States. The number of Americans who during their lives have been neglected and/or physically and sexually assaulted by substance-abusing parents is a significant portion of our population.[92]

In the most comprehensive analysis ever undertaken of the impact of substance abuse on child abuse and neglect, the National Center on Addiction and Substance Abuse at Columbia University documented the effects of parental abuse of alcohol and drugs on children and its effects on the child welfare system. In its 1999 report, **No Safe Haven: Children of Substance-Abusing Parents**, the National Center reports that *substance abuse and addiction are the primary causes of the dramatic rise in child abuse and neglect and the immeasurable increase in the complexity of cases since the mid-1980s.* Further, it states that children whose parents abuse drugs and alcohol are almost **three times (2.7) likelier to be abused** and more than **four times (4.2) likelier to be neglected** than children of parents who are not substance abusers.[93]

As part of its two-year analysis, The National Center conducted the first nationwide survey of child welfare agencies and family courts on this issue. It found that:

- Nearly 80 percent of respondents report that substance abuse causes or contributes to at least half of all cases of child maltreatment; 39.7 percent say it is a factor in over 75 percent of cases;

- Over 80 percent report that parents who abuse or neglect their children most commonly abuse a combination of alcohol and drugs; 7.7 percent cite alcohol alone;

- Overall, 89.3 percent of respondents recognize alcohol as the leading substance of choice and abuse among parents;
- 45.8 percent say that cases of illegal drugs involve crack cocaine. One in five (20.5 percent) say that cases of illegal drugs involve marijuana;
- Three of four survey respondents (75.7 percent) say that children of substance-abusing parents are likelier to enter foster care, and 73 percent say that children of substance-abusing parents stay longer in foster care than do other children.[94]

Substance Abuse and Child Neglect, Physical Abuse, and Sexual Abuse

Child Neglect

Child neglect is a frequent problem among addicted parents. The use of precious resources to pay for drugs and alcohol often results in lack of food, heat, or adequate clothing for these children. Poor child health and hygiene can be the result when parents are so preoccupied with getting high that they fail to attend to everyday issues, like making sure their children are clean and that they get regular medical and dental check ups.

Time spent binging or recovering from hangovers or withdrawal symptoms, or spent raising money to support addictions, often leaves children to fend for themselves. This lack of attention when parents are at home or the lack of supervision when they spend extended hours or days outside the household can have damaging psychological consequences for children and place them in dangerous physical jeopardy as well.

Infants in Massachusetts have died from being left alone for days without nourishment and from fires and accidents that occurred when substance abusing parents were away for extended periods without arranging for competent child care.

Sadly, many children are the victims of alcohol and drug abuse while they are still in the womb. Nationwide, 500,000 babies are born each year having been exposed to illicit drugs and alcohol during pregnancy.[95] These children tend to be medically fragile as newborns and are often born prematurely or with low birth weight. For some, the effects of Fetal Alcohol Syndrome and its related mental retardation will become more pronounced as they grow older.

Because the rate of HIV infection is higher among women who abuse drugs, the children of these mothers are also at high risk of contracting the AIDS virus before they are born. Predictably, the special health and emotional needs of these children and the extra demands they place on already compromised parents often increase the likelihood that they will suffer repeated and chronic abuse or neglect.

Physical Abuse

According to the National Center, the link between alcohol abuse and physical child abuse is not surprising given that almost half of all violent crime is connected with concurrent alcohol abuse. The lowering of inhibitions and the heightening of aggressive feelings that alcohol can cause are a damaging combination for children trying to grow up in these homes. Almost any type of normal childhood behavior, e.g. crying, fussing, disobeying, can provide the justification for a violent response.

Similarly, abuse of cocaine and other illicit substances can cause or contribute to violent behavior.[96] A 1998 National Center report on substance abuse within the prison population found that 60 percent of adults arrested in the U.S. for violent crime tested positive for drugs.[97] The excitability, irritability and paranoia induced by some illicit drugs can place children at high risk of being abused or of being exposed to violence and danger that are intrinsic to the drug scene.

Sexual Abuse

Sexual abuse among these children is not uncommon since they are often exposed to non-related addicted adults. Even when substance-abusing parents are in the home, their condition may not allow for any meaningful protection. Because alcohol leads to a lowering of inhibitions in many people, children of alcoholics face a higher risk of sexual abuse by their own parents. It is estimated that between 30 to 40 percent of all reported incest cases involve an alcoholic parent.[98]

Intergenerational Links Between Child Abuse and Substance Abuse

The intergenerational effects of child abuse and substance abuse are often interwoven. Children of substance-abusing parents are at high risk of developing their own substance abuse problems later on. For children growing up in these homes who are entering adolescence or adulthood, alcohol or drugs can be a way to cope with depression, low self-esteem and other psychological effects of their victimization. Their early use of substances may lead to aggressive, delinquent or anti-social behaviors that are themselves risks for substance abuse. Posttraumatic Stress Disorder, often related to experiences of sexual abuse or violence, is also correlated with substance abuse.[99] Young women who abuse substances increase the chances that they will in turn maltreat their children.

Many addicted mothers are raising their children alone because fathers have left their families. Among these women, substance abuse most frequently occurs as one of a cluster of serious problems including physical and sexual abuse, stress, social isolation, financial crisis, unemployment, depression, and family histories of these problems. Nearly half of women seeking alcoholism treatment report a childhood of physical or sexual abuse by a parent.[100] The prevalence of sexual abuse histories among substance abusers is two to four times higher than in the general population.[101]

The increasingly early exposure of young adolescent women to alcohol and drug abuse has led child welfare providers to observe that these addicted women are more deeply troubled than their counterparts 20 years ago. Their social skills and emotional maturity have been so arrested that they can rarely take on the challenges of raising children.[102] As the National Center report makes clear, infants and children need lots of time, attention and patience, three things that an alcoholic or drug addict is likely to lack.

The Fiscal Burden

According to the 2001 report, **Shoveling Up: The Impact of Substance Abuse on State Budgets**, in 1998 states spent $81.3 billion dollars or 13 percent of their state dollars dealing with the aftereffects of alcohol and substance abuse. (Federal matching dollars or local or private sector costs were *not* included.) Of that figure, $24.9 billion dollars was spent specifically to deal with the impact of substance abuse on children.

This latest report indicates that in Massachusetts nearly $302 million dollars were spent of child welfare services that year. *Nearly 76 percent or approximately $228 million dollars were spent on services that were provided to children because of conditions that were "caused or exacerbated by alcohol or drug abuse."*[101]

Of each $1 spent by the states, 96 cents is spent dealing with the aftereffects of the problem while only 4 cents is spent on prevention and treatment. This shortsighted approach requires a revolution in thinking, according to Joseph Califano, Jr., Chairman of the National Center and former U.S. Secretary for Health, Education, and Welfare. A focused and sustained prevention initiative would have enormous consequences since, as Califano points out, "A child who reaches age 21 without abusing alcohol or using drugs is virtually certain never to do so."

Given the strong links between child abuse and alcohol and drug abuse described above, it is clear that the prevention of these two devastating social problems are inextricably tied. As Califano concludes: "Governors who want to curb child abuse, teen pregnancy, and domestic violence and further reduce welfare rolls, must face up to this reality: unless they prevent and treat alcohol and drug abuse and addiction, their other well-intentioned efforts are doomed."

The recommendations put forth by the National Center on Addiction and Substance Abuse in its seminal report, **No Safe Haven**, are comprehensive and reflect an in-depth understanding of how substance abuse impacts children and state systems charged with their care and protection. Discussion of the many specific recommendations is not possible here, however, the following principles and general recommendations delineate the areas in which change must occur.

Principles That Should Underlie Public Policy and Program Efforts:

- Every child has a right to have his or her substance-abusing parents get a fair shot at recovery with timely and comprehensive treatment.
- Every child has a right to be free of drug-and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment or despite treatment are unable to conquer their abuse and addiction.

- Every child has a right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

- The goal of the child welfare system is to form and support safe, nurturing families for children - where possible within the biological family and where not possible with an adoptive family.

The National Center makes the following proposals:

- **Start with Prevention.**
  Prevention of alcohol and substance abuse among adolescents should be the top priority. Secondly, for parents involved with substances, preventing child maltreatment within their families is essential. Social service providers, health professionals, and treatment providers should capitalize on pregnancy as an opportunity to prevent child maltreatment by offering comprehensive and appropriate treatment to substance-abusing pregnant women. Linking these women to home visiting services should be a priority.

- **Reform Child Welfare Practice.**
  Child welfare officials and family court judges must employ practices that respond effectively to substance abuse including: protocols to screen and assess for parental substance abuse in every investigation of child abuse and neglect; timely and appropriate treatment for parents; strategies to motivate parents; prevention of and planning for relapse; and facilitating adoption for children when parents fail to engage in treatment.

- **Fund comprehensive treatment.**
  Comprehensive treatment that is timely and appropriate for parents is the linchpin of strategies to prevent further maltreatment by substance-abusing parents. The supply of treatment must be greatly increased to meet the serious demand. It is essential that treatment include interventions targeted at the children of parents in treatment in order to break the tragic cycle of maltreatment and addiction.

- **Provide substance abuse training.**
  Social service providers, from agency directors to frontline child welfare workers; judicial officials, from judges to lawyers; and health and social service professionals who serve these families need training in the nature and detection of substance abuse and addiction, and what to do when they spot it. Substance abuse training should be a required element in certification and licensing requirements for child welfare professionals.

- **Evaluate outcomes, increase research and improve data systems.**
  Child welfare officials and family court judges need to collect better data so that the outcomes of their efforts and decisions can be evaluated in cases involving substance-abusing parents that maltreat their children. Investments

in research are also required to better understand the causes of substance abuse and addiction and improve treatment outcomes.

RECOMMENDATIONS

1. **Develop a comprehensive statewide plan for Massachusetts aimed at preventing alcohol and substance abuse and treating affected parents and children.**

   To develop this state plan, a Task Force including lay persons and professionals with expertise in the areas of substance abuse and child maltreatment should be convened by an appropriate state agency or the legislature. The plan should identify immediate and long-range strategies to prevent the abuse of substances within the adolescent and young adult population; ensure comprehensive treatment of parents and children affected by these addictions; and establish training programs for workers in the social service, health care and judicial systems. This plan should be coordinated closely with parallel efforts aimed at preventing and treating child abuse and neglect.

2. **Establish within the Department of Social Services a unit of Substance Abuse Specialists to provide consultation to each local DSS Area Office and training to frontline workers.**

   The Department has become a national leader in coordinating domestic violence and child abuse training and protocols for practice. Applying the same successful strategies, it must now work to establish a parallel level of expertise and coordination to improve outcomes for children and families affected by alcohol and substance abuse. It should explore partnerships with national groups, including the National Center on Addiction and Substance Abuse, which is seeking to establish pilots within state child welfare agencies.

CHAPTER 5

Children Living Without Homes

Families now comprise 40 percent of the U.S. homeless population. Despite increased prosperity over the past decade, more than one million American children are homeless today. The Better Homes Fund in its 1999 research and policy report, **Homeless Children: America's New Outcasts,** describes the physical and emotional conditions of these youngest citizens and how their lives are frequently linked to child abuse, neglect and violence.[104]

In Massachusetts **the number of homeless families increased by over 100 percent, to 10,000 families,** from 1990 to 1997.[105] Since a homeless family is defined as a mother and two children, we can estimate that approximately **20,000 children are homeless in our state**. This is a dramatic increase from the estimated 1,600 homeless children only a decade ago.[106] *Currently, Massachusetts ranks fourth highest in the country in terms of per capita income, yet it ranks 24th highest in the number of children living at risk of homelessness.*[107]

Homelessness and Child Neglect

Mothers who find themselves homeless struggle against conditions that undermine the basic physical and emotional well-being of their children. According to the Worcester Family Research Project and The Better Homes Fund, **homeless children are hungry more than twice as often as other children**. Two-thirds report that they worry they won't have enough to eat.[108]

For these children, poor nutrition often begins prior to their homelessness. Almost one-third of low-income families do not have enough money to prepare three meals a day. Cash assistance and food stamps do not cover food costs when rents are high. Lack of adequate food is especially common during winter when cash must be used to pay for heat. Even when these families are housed in homeless shelters, their children can still be undernourished. Although shelters provide nutritionally balanced food, meals are usually served at strictly scheduled times that can be easily missed when mothers are searching for housing and work. Food preparation for homeless families living in hotels and motels can be challenging. Lack of refrigeration and the means to cook usually result in fast food meals or no regular hot meals.[109]

Homeless children are in fair or poor health twice as often as other children. Homeless newborns have higher rates of low birth weight and need special care after birth four times as often as other children. Exposure to the communal conditions of shelter life, including overcrowding and shared food preparation, increases the risk of disease and infection. Compared to other children, homeless children suffer twice as many ear infections and five times more diarrheal and stomach problems. Anemia, eczema, and headaches are other chronic illnesses experienced by homeless infants, toddlers, and school-age children. Childhood asthma is found in very high rates because of substandard housing conditions, crowded shelters that facilitate the spread of viral infections, and exposure to smoke and other environmental allergens.[110]

Despite the efforts of dedicated staff, many shelters are noisy and chaotic, too hot or cold, crowded, and lack comfortable surroundings. Children usually sleep in the same room with their parents and siblings, and bathroom facilities are shared with other families. When a homeless child gets sick in this setting, a mother has no chance of providing her child with a private and quiet place to rest. Preparing a special diet in a shelter can also be very difficult. Getting medical care for a sick child, something most parents do routinely can become overwhelming and even ill advised. Homeless parents are understandably reluctant to take their sick children out in the weather and have them negotiate several buses to medical care. Many shelters are not located near public transportation. Lack of availability of other adults to watch a sibling is another barrier to adequate health care.[111]

Clearly, poverty, the rising cost of living, and lack of affordable housing are factors that can push families into homelessness. For many, however, histories of victimization and violence have played a role in making them and their children vulnerable to losing their homes. The intergenerational links among violence, child abuse, and homelessness are startling.

Although homelessness does not cause child abuse, it can lead to conditions in which child maltreatment is more likely to occur.[112] For example, the Worcester Family Research Project found that among homeless children, 8 percent had been physically abused - twice the rate of other children. The study also showed 8 percent had been sexually abused, and 35 percent had been the subject of a child protection investigation.[113]

Homeless children are at high risk for foster care, with 12 percent placed in foster care, compared to just over 1 percent of other children.[114] The intergenerational links between placement in foster care as a child and later adult homelessness should also be noted. According to the Child Welfare League of America, 70 percent of homeless mothers who were in foster care as children have had at least one of their own children placed in foster care.[115] The Better Homes Fund research confirms that a startling 44 percent of homeless mothers lived outside their homes at some point during their childhood. Of these, 20 percent were placed in foster care.[116] In fact, *foster care is one of only two childhood risk factors that predicts family homelessness during adulthood* – the second being maternal substance abuse.[117]

Of the overall family homeless population, 66 percent were violently abused before age 18 by a childhood caretaker or other adult in the household, and 43 percent were sexually molested as children.[118] In adulthood, 63 percent report violent abuse by an intimate male partner while 25 percent report physical or sexual assault during adulthood by someone other than an intimate partner.[119] When the violence from their childhood is combined with their experiences as adults, *an incredible 92 percent of homeless mothers have been severely physically or sexually assaulted while 88 percent have been violently abused by a family member or intimate partner.*[120]

Nearly 25 percent of homeless children have witnessed these acts of violence within their families. Fifteen percent have seen their father hit their mother while 11 percent report having seen their mother abused by a male partner. As described earlier in this report, the impact on children of witnessing violence can have a profoundly negative effect on their behavior and emotional well-being.

Repeated acts of violence, experienced during childhood and then into adulthood, have left many homeless mothers with serious psychological problems whose manifestations can have a major impact on the health and emotional well-being of their children. For example, 36 percent of these women, three times the rate of other women, have experienced Posttraumatic Stress Disorder. Forty-five (45) percent have had a Major Depressive Disorder, twice the rate of other women. Thirty-one (31) percent have attempted suicide at least once, and 12 percent have been hospitalized for mental illness.[121]

Homelessness and Mental Health Problems

It is not surprising that the very condition of being homeless is emotionally abusive to the vast majority of these children. Chronic stress, worries, fears, and disruptions are the mainstays of their lives. Within a single year, 97 percent of homeless children move, many up to three times, and more than 30 percent are evicted from housing according to the Worcester Family Research project.

Family homelessness researcher Dr. Ellen Bassuk and her colleagues report that the accumulated impact of severe environmental stresses under which homeless babies live results in a significant slowing of their physical, cognitive and emotional development.[122] They report that **more than 20 percent of homeless children between 3 and 6 years of age are extremely distressed and have emotional problems that are serious enough to require professional care**. Twelve (12) percent have clinical problems such as anxiety, depression, and withdrawal. Sixteen (16) percent have behavior problems manifested by severe aggression, and hostility. Speech and stammering problems are six times more likely to occur among homeless children.[123]

Homeless children between 6 and 17 years of age struggle with very high rates of mental health problems. Nearly one-third have at least one major mental disorder that interferes with their daily activities; nearly half have problems such as anxiety, depression or withdrawal; and over one-third manifest delinquent or aggressive behavior. Unfortunately, less than one-third of homeless children who might experience relief through treatment are receiving it. Most disturbing, the likelihood of their receiving treatment drops as the severity of their mental illness increases.[124]

Homelessness and Educational Neglect

Sadly, at least one-fifth of homeless children do not attend school. Children's educational needs are often pushed aside by the daily demands of finding food and shelter. Improvised living arrangements are often too short in duration to make enrolling in a new school worthwhile. Even when enrollment is sought, lack of prior academic and medical records or lack of transportation from shelters to school can create obstacles.[125]

For those who manage to attend, their physical and emotional status can make academic success difficult. Fourteen (14) percent of homeless children are diagnosed with learning disabilities, including dyslexia or speech and language problems. The Better Homes Fund reports that 36 percent of homeless children have repeated a grade, while 14 percent were suspended from school. These effects that result from their academic and emotional problems occur at double the rate of other children.[126]

It is not difficult to see that academic failure resulting from homelessness and its effects can lead to school drop-out which, in turn, has implications for future poverty and homelessness.

Homelessness and Substance Abuse

Alcohol and drug problems are evident in 43 percent of the fathers of homeless children. Although most men do not live with their homeless children, 70 percent of fathers are in touch with them. Similarly, 40 percent of homeless mothers report alcohol or drug dependency at some time in their lives.[127] As we have seen in the previous chapter, the impact of parental substance abuse is most often devastating for children.

Although the relationship among homelessness and alcohol and drug abuse, poverty, domestic violence, child abuse and mental illness is complex, and intergenerational factors make it difficult to sort out which problem or combination of problems served to trigger others, one thing is clear – children living in these families do not go unscathed. Often they are physically and emotionally defeated by the chronic stress and instability in their young lives.

The Better Homes Fund in its report, **Homeless Children: America's New Outcasts**, provides an in-depth and comprehensive set of recommendations to address the plight of these children. Its seven-point platform includes:

- Protecting the health of homeless children;

- Eliminating hunger and food insecurity;
- Improving mental health services;
- Preventing unnecessary separation of families;
- Expanding violence prevention, treatment, and follow-up services;
- Ensuring access to school and opportunities for success in school; and
- Supporting education, training, and work for homeless families.

Long-term solutions are also proposed, including developing an adequate supply of decent affordable housing, and maximizing the economic resources of poor families.

MCC supports this comprehensive agenda and proposes the following recommendations aimed specifically at addressing the pressing needs of abused, neglected and traumatized homeless children.

RECOMMENDATIONS:

1. **Support the hiring of trauma specialists within family shelters and train staff to identify children who have suffered from abuse, neglect or who have witnessed violence.**

   Trained trauma specialists can identify women and children with histories of violence, provide a range of support and psycho-educational groups and, when necessary, family therapy and counseling for children.

   Staff that have contact with homeless mothers and children should be enabled to identify, empower, and, when necessary, refer for services women and children with histories of violent victimization. Training direct service staff about the impact of abuse, neglect and domestic violence on children will ensure greater responsiveness to their special needs.

2. **Fund the hiring of experienced case managers within family shelters.**

   Shelter staff meet numerous daily demands of shelter life, including orienting new residents, planning and providing meals, implementing recreational activities for children, etc. In order to facilitate integrated, comprehensive services for homeless mothers and their children across state and private agencies, shelters must be funded to supplement their staff with experienced case managers to assist each family in their transition to more stable and permanent housing.

3. **Link homeless mothers and their children in shelters to newborn home visitation, parent aide services, and local family resource centers.**

   Homeless new mothers of all ages could benefit substantially from newborn home visitation services during their stays in shelters and as they transition into more permanent housing. Parent aides could also provide consistent support to mothers with older children and help them address a range of personal and parenting issues. Linking these fragile families to a range of supports available through local family resource centers could help stabilize them and counter the effects of isolation and depression that many of them face.

4. Ensure that transportation needs of homeless mothers and their children are met.

Special efforts must be made to remove transportation barriers that impact on the access of children and their mothers to health and mental health care or on their ability to attend school or locate housing and jobs.

SECTION III

Protecting Our Children

The system the nation has developed to respond to child abuse and neglect is failing. It is not a question of acute failure of a single element of the system; there is a chronic and critical multiple organ failure.

U.S. Advisory Board on Child Abuse and Neglect - 1990

CHAPTER 6

The Child Protection System

A Brief Overview of the Massachusetts System

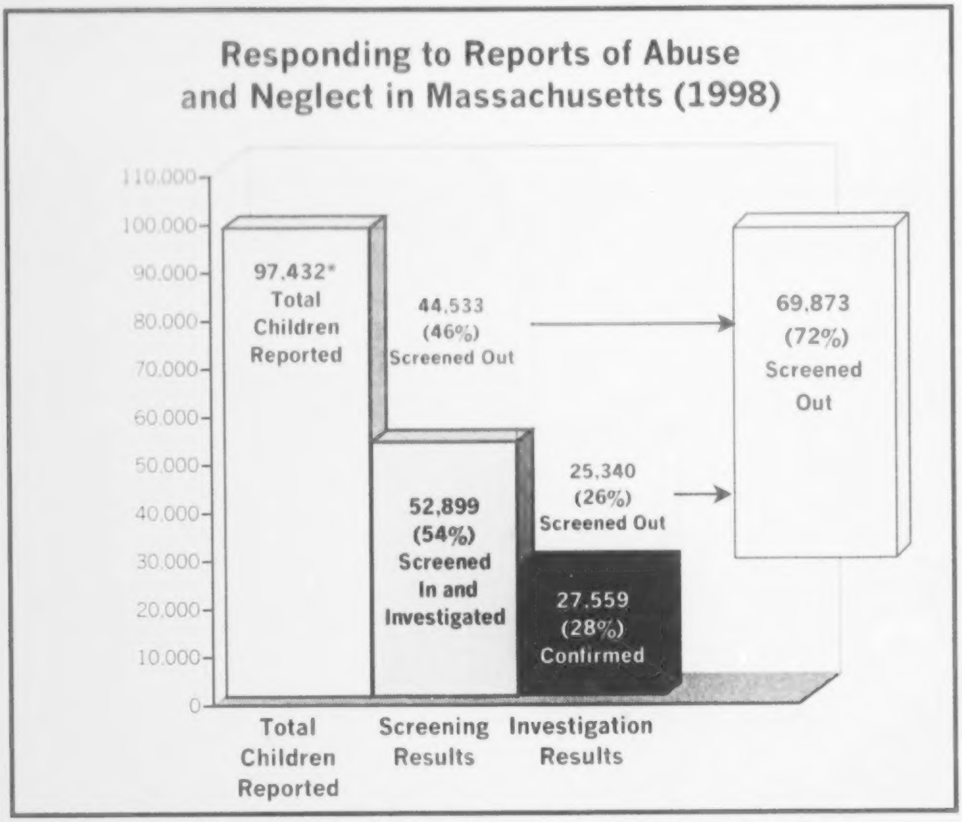
Massachusetts' child abuse reporting law identifies over thirty types of professionals that must report suspected abuse or neglect immediately to the Department of Social Services (DSS). A written report or 51A must be filed within forty-eight hours.

The law identifies physical or emotional injury resulting from abuse, sexual abuse, neglect, malnutrition, and drug addition at birth as the conditions that require reporting. Citizens who have reasonable cause to believe a child is suffering from or has died as a result of abuse are also encouraged to report.[128]

The law intends to help end the abuse inflicted on our state's children. However, current strict legal interpretation of the mandate has meant that in 1998, the most recent year for which full data are available, abuse and neglect were formally confirmed among only 28 percent of children reported that year.[129]

Of the 97,432 children reported in 1998,[130] 54 percent or 52,899 were screened in to DSS for an investigation. The remaining 46 percent or 44,533 were screened out. Of those investigated, child abuse or neglect was supported among only 27,559 children (25,340 were screened out).

This means that **72 percent of all reported cases or 69,873 children were screened out either immediately, or after investigation without any services being offered.**



Responding to Reports of Abuse and Neglect in Massachusetts (1998)

*This number includes children who may have been reported more than once for the same incident of abuse or neglect, or children who were reported more than once for different types of abuse in the same year.

Source: Massachusetts Department of Social Services (2000)

A closer look at the Massachusetts system and innovations in other states' systems will help us understand how we can better meet the needs of these children and families.

In the present system, when a report falls within the state's definition of child abuse or neglect, referral to an investigation unit is made to determine if the child is at substantial risk of imminent harm. The Massachusetts law states that the Department of Social Services must carry out the following protocol:

1. Investigate and evaluate the information reported;
2. Evaluate the household of the child named in the report and make a written determination of the risk of physical or emotional injury to any other children in the same household;
3. Take a child into immediate temporary custody if the Department has reasonable cause to believe that the removal of the child is necessary to protect him from further abuse or neglect;

4. Notify the District Attorney within 45 days of the service plan, if any, developed for such child and his family. In all cases in which the Department determines that a report of abuse or neglect is not substantiated, the Department shall notify in writing any and all sources or recipients of information in connection with the investigation that the report has not been substantiated.[131]

As is typical in child protective systems across the country, services are offered to the family only if the allegations of abuse or neglect are confirmed.[132] Depending on the severity of the maltreatment and the level of risk, the child might be removed from the home and placed in out-of-home care, or remain at home under the supervision of child protective services.[133] However, comprehensive service plans which address all of the child's and family's needs are not always developed, due to such factors as case worker overload, and lack of resources.[134]

In Massachusetts, if a case does not meet the legal criteria for an investigation, it is screened out and no services are provided to the child or family. Cases are screened out for a variety of reasons, including: the child is over eighteen; a non-caretaker is alleged to have committed the abuse, in which case the police and not DSS are responsible; the case is already active with DSS; or there is lack of evidence.[135] Some cases are screened out even though serious harm has been inflicted on a child, for example, when abuse is committed by a caretaker that no longer poses a threat to the child.

If a case is investigated but not substantiated or confirmed, services are not likely to be provided. In a high percentage of these cases, however, there are underlying issues within the family that, if not addressed, could be harmful to the child's future well-being and safety. Many of these reported families could clearly benefit from a range of family supports. Currently, case management services that could plan for and link families to these supports are not provided.

Conventional Child Protective Services

Conventional child protection systems are often criticized for being "over-inclusive," that is, many families that could be provided more appropriate informal supports in the community are the subject of costly and intrusive investigations by the state. This practice impacts the higher-risk families who may not receive full attention because they are competing in a system with limited resources. The system can also be "under-inclusive," denying services to families who could benefit from them, but who are turned away because they do not fit the strict legal criteria required to get their foot in the door.[136]

Characteristics of traditional child protective services, then, are that they are crisis-oriented, responding only after a serious family problem has resulted in harm to a child; they respond to all reports of abuse/neglect in a unilateral, investigative mode; and they provide services only when cases are formally within the system.[137]

In a unilateral investigation model, the caseworker focuses on the specific reported incident and attempts to prove or disprove its occurrence. Another important focus is on who caused or inflicted the harm. This investigation model by its very nature highlights family weaknesses and failures. Predictably, it often results in defensive families who see themselves coerced by the state's authority to participate in services they may not believe are necessary or appropriate. Because this model's focus is not on understanding the underlying stressors that may have caused the abuse, families may find themselves no better able to cope with or eliminate those factors after the state closes their case.

Because the state vests full authority for such cases within a single agency, caseworkers are not predisposed to collaborate on each case, and so are often unaware of other agencies involved with the family. Lack of coordination can result in competing or conflicting treatment plans, mixed messages to the family, and unnecessary costs. Though in Massachusetts cases involving serious bodily injury must be reported by DSS to the District Attorney, this collaboration focuses uniquely on issues of prosecution and not treatment.

CHAPTER 7

Multi-Tracking: A Differential Response System

Currently, there is a national trend away from the "one-size-fits-all"[138] system of dealing with cases, towards a differential, customized response to reports of child abuse and neglect.

In 1988, the National Association of Public Child Welfare Administrators concluded that child protective services was in need of reform and called for a three-tiered system of response. Such a system would narrow the focus of child protective services to the more serious cases, expand family support systems, and introduce an adequately funded child well-being system.[139]

The goals of reform were to create a system that could quickly protect child victims of abuse and neglect, while also providing services to support at-risk families so that their children could remain at home. By working to support families before risk factors resulted in serious abuse or neglect, families would be more cooperative, less defensive, and more open to participating in services. In turn, children would be better protected.

Child protective services would retain primary responsibility for the most serious cases of abuse and neglect, while other community resources would play an active supporting role. Likewise, in less serious cases, community resources would have the primary responsibility, but would also draw on other partners on a case-by-case basis.[140]

Since 1990 several states have led the way in reshaping their child protection systems to reflect a differential response to reports.[141] Over ten state legislatures have moved in this direction, including Arizona, Florida, Hawaii, Iowa, Kentucky, Missouri, Nevada, North Dakota, Texas, and Virginia.

These states recognize the unique opportunity their systems have to identify families at risk of abuse or neglect before maltreatment happens.[142] They have come to realize the limitations of making a single state agency solely responsible for delivering services to families reported for abuse and neglect. We describe below the experiences of two states.

Missouri's Dual-Track Approach

In 1994, Missouri developed a new strategy to deal with the overwhelming number of reports entering its system. The underlying principle behind reform was that families entering the Division of Family Services (DFS) had differing needs and required flexible responses from the state and the community. DFS implemented a dual track system where reports would either be triaged to "Investigations" or referred to "Family Assessments."

Missouri's system distinguishes between criminal maltreatment and maltreatment due to social malfunctioning within the family system.[143] Cases involving serious physical and emotional abuse, and all cases of sexual abuse, which require law enforcement intervention, are sent to the Investigations track. Cases of mild physical abuse and neglect are handled by Family Assessments.

In the latter track, the caseworker determines the degree of risk to the child, assesses the family's need for assistance, and collaborates with community partners to support the family. There is minimal lag time between initial contact with the family and intervention because of partnerships with community resources, such as schools and churches. The services provided by community agencies address underlying problems in the family, and are not focused uniquely on the incident of the report. Such an approach helps the family face its problems in a non-threatening and productive manner.

This collaboration has helped DFS quickly increase the number of people and resources available to serve children and families, without having to increase its own staffing levels. The method has reduced the caseload burden for DFS workers without compromising child safety.[144]

The dual track pilot program was observed to be beneficial in many other aspects, as well. A 1998 evaluation of the system by the Institute of Applied Research revealed many positive effects:[145]

- Hotline reports declined;
- Reported incidents in which action was taken increased.;
- Children were made safer sooner;
- Recidivism decreased overall;
- Children spent less time in out-of-home care though removal rates remained the same;
- Services were delivered more quickly;
- Utilization of community resources was greater;
- Cooperation of families improved;
- Families were more satisfied and felt more involved in decision making;

- Caseworkers judged the system to be more effective; and.
- Investigations were not adversely affected and may have been enhanced.

Overall, the Missouri dual track system, and others like it, demonstrate that the safety of children and the well-being of families are better safeguarded in a system where:

- The response to families is immediate, i.e. there is no lag time between the initial contact with the family and intervention.
- The worker approaches the family with sensitivity to the underlying family problems and conditions, not just the particular incident of abuse or neglect.
- The worker's attitude is positive and supportive, rather than accusatory or punitive.
- Local agencies are actively involved in a collaborative effort with the child welfare agency to support the family and the children.[146]

The Federal Mandate: The Adoption and Safe Families Act (ASFA)

In November 1997, the federal government built upon the experience of professionals and the reform-oriented states with the enactment of Public Law 105-89, entitled the Adoption and Safe Families Act (ASFA). This act was the first federal legislation to emphasize child safety as a top priority over all other social policy issues.[147]

Impetus for the law was generated by a number of highly publicized child deaths, the increasing number of children in care of child protective services (more children entering each year than exiting), and the belief that many states were emphasizing family preservation at the expense of child safety. Central themes of the law include:

- Safety of the child is the paramount concern.
- Foster care should be temporary and short term.
- Permanency planning should begin as soon as the child enters care.
- Services to promote reunification should be provided more quickly and intensively.
- Focus should be on results and accountability, as opposed to the process.
- There should be an increased emphasis on parental responsibility.[148]

Proposal for a Multi-Track System for Massachusetts

The following proposed multi-track system for Massachusetts would assist the state to comply with the provisions of ASFA described above. Both seek to ensure the well-being of children in the timeliest manner. Both seek an approach to cases that takes into consideration the overall environment of the child, and not just the presenting problem.

After reviewing response models in other states, Summit Work Groups agreed that a differential response system could address inadequacies in the current Massachusetts system. However, the Groups determined that a multi-track, rather than a dual-track, system in Massachusetts, would lead to more appropriate investigations, assessments and services.

The diagram on page 76 outlines some key features of the proposed multi-track system.

Under this model, all "51A" reports would be assessed by DSS at intake to determine the most appropriate track. This initial assessment would include: interviews with the reporter of the 51A, the child, siblings, parents, and the suspected abuser; an observation of the child's environment; an observation of the interactions among family members; and an analysis of the collected information to reach a determination about the child's safety and the validity of the report. Once the child and family have been triaged into the appropriate track, they would participate in an assessment to determine appropriate services or supports.

Screened Out Cases

If after investigation a report is found to be unsubstantiated or not supported, it will likely be screened out. A child would be deemed safe if "an analysis of all available information leads to the conclusion that the child, in the current living arrangement, is not in imminent danger and that no safety interventions are needed."[149] Such a case would include one where the perpetrator is no longer a threat or the original claim is deemed invalid. Even in such an unsubstantiated case, however, the child may have experienced some degree of abuse or neglect or inadequate parenting, and the family may be receptive to participating voluntarily in services at the community level.

Cases that do not meet the legal criteria to be screened in and investigated can also involve at-risk families. Under the proposed model, these screened out families would no longer be turned away without help, but would be directed to other more appropriate resources in the community. This would reduce the likelihood of future reports to DSS that could be generated if, without intervention, family problems worsened and children were more seriously harmed.

Families described above would be referred to local family support collaboratives, i.e. "Community Connections" sites, where they would be assisted by site coordinators and, if appropriate, Family Support Teams that would help them identify and address problems. All such services would be offered on a voluntary basis. (For a description of "Community Connections," see Chapter 16.)

Effectively addressing screened out and unsubstantiated cases within a multi-track model cannot be accomplished without a strong network of family and community supports across the state.

Low risk cases

After investigation, some cases are screened in as "low risk. Under the proposed multi-track model, these least serious DSS cases could also be referred to local family support collaboratives and Family Support Teams for assessment and services. Community workers trained in the principles of strength-based family support would help families in the selection and delivery of local services and, when appropriate, coordinate family conferencing through the help of Family Support Teams. DSS would have minimal involvement and case management, if needed, could be provided by identified local agencies. This would allow DSS to expend its caseworker resources on more serious cases.

Moderate risk cases

The moderately serious cases that involve reasonable risk of harm would be referred to the DSS Multidisciplinary Assessment Teams (MDATs). These teams would be responsible for determining whether the child should be removed from the home, or what other measures might be taken to reduce the level of risk.[150] MDAT reviews would be conducted by workers trained in the principles of strength-based family support, and involve other professional disciplines to assist in the assessment process. A statewide system of MDATs currently exists in nearly all of the DSS Area Offices.

Serious risk cases

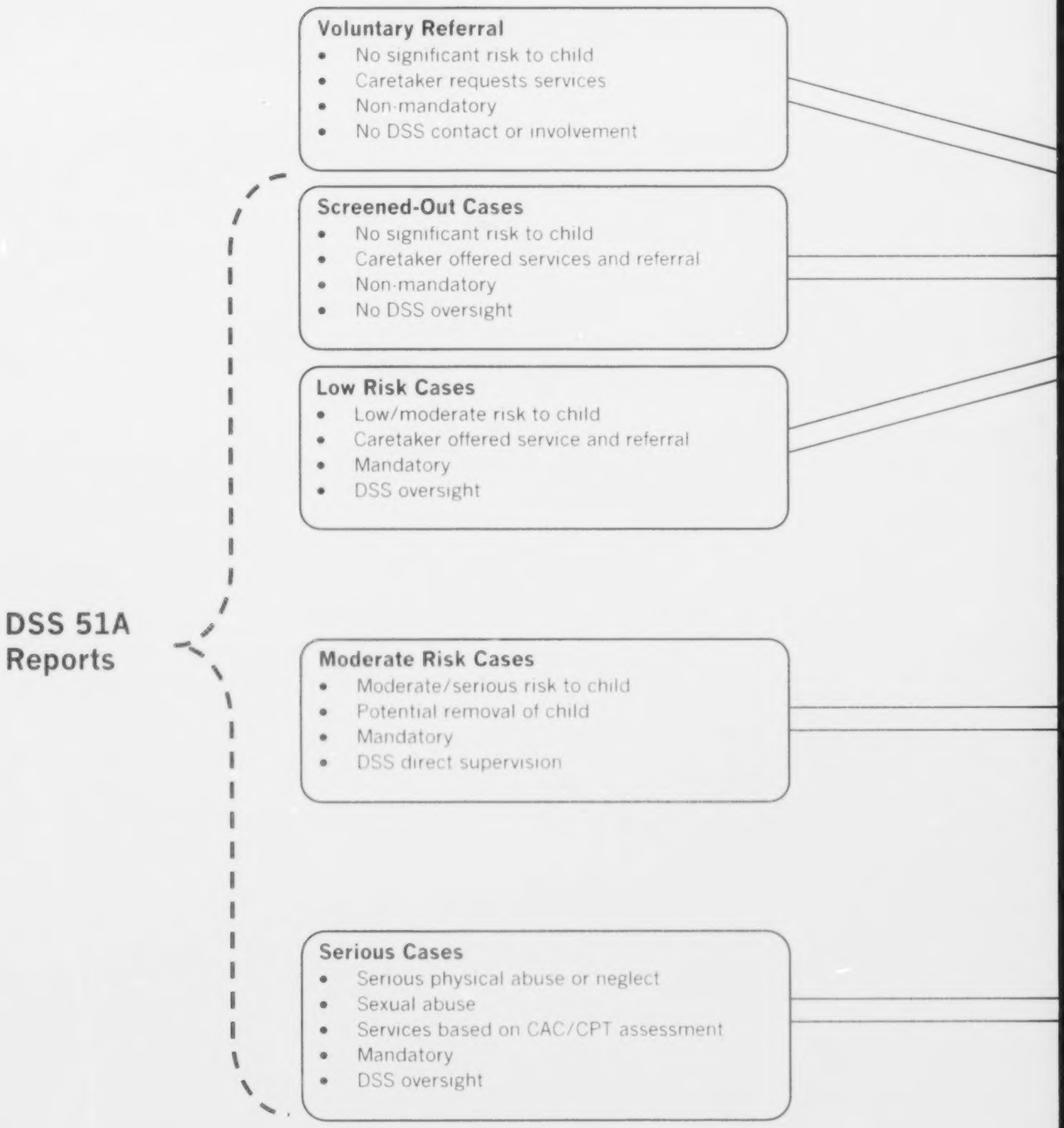
The most seriously at-risk children involved in sexual abuse and serious physical abuse and neglect would be referred to Children's Advocacy Centers (CACs). The CAC system would most resemble the traditional investigation system, and would in most cases involve law enforcement agencies, and the courts. Medical evaluations would be conducted by pediatric experts trained in child abuse and neglect who would operate within hospital-based Child Protection Teams (CPTs). CPTs could function independently, but would be collaborating members of local CACs, essentially serving as their medical arm.

A full discussion of MDATs, CACs, and hospital-based CPTs can be found in Chapter 8.

The system would have flexibility so that a case initially screened into one track could be shifted into another if new information or developments warranted that move. In this new system, services would be provided to a much greater number of families and children and DSS could focus its resources more efficiently.

PROPOSED MULTI-TRACK

TYPE OF CASE



DSS 51A Reports

Voluntary Referral
- No significant risk to child
- Caretaker requests services
- Non-mandatory
- No DSS contact or involvement

Screened-Out Cases
- No significant risk to child
- Caretaker offered services and referral
- Non-mandatory
- No DSS oversight

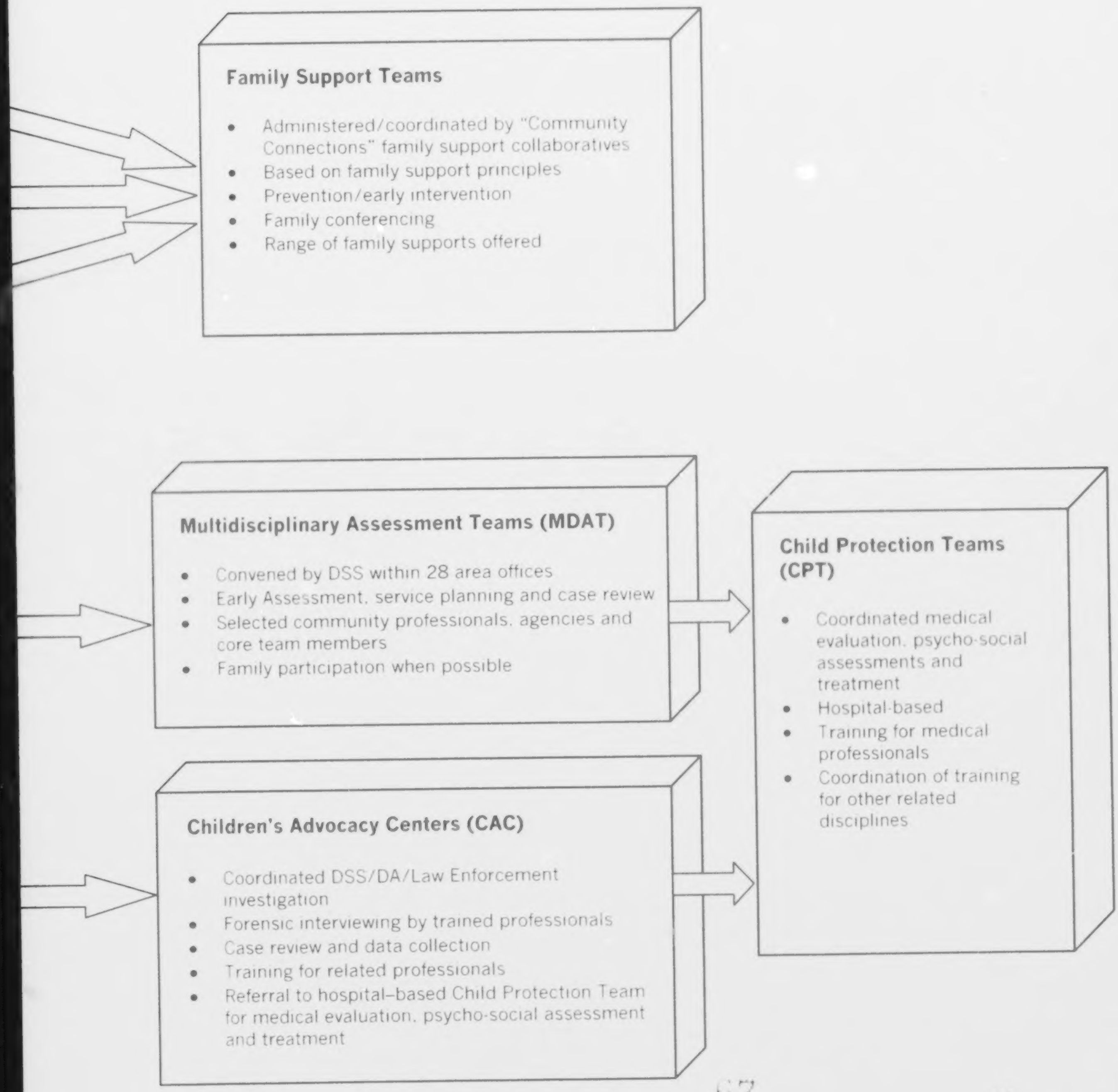
Low Risk Cases
- Low/moderate risk to child
- Caretaker offered service and referral
- Mandatory
- DSS oversight

Moderate Risk Cases
- Moderate/serious risk to child
- Potential removal of child
- Mandatory
- DSS direct supervision

Serious Cases
- Serious physical abuse or neglect
- Sexual abuse
- Services based on CAC/CPT assessment
- Mandatory
- DSS oversight

& ASSESSMENT MODEL

MULTIDISCIPLINARY TEAMS / FEATURES



Family Support Teams

- Administered/coordinated by "Community Connections" family support collaboratives
- Based on family support principles
- Prevention/early intervention
- Family conferencing
- Range of family supports offered

Multidisciplinary Assessment Teams (MDAT)

- Convened by DSS within 28 area offices
- Early Assessment, service planning and case review
- Selected community professionals, agencies and core team members
- Family participation when possible

Child Protection Teams (CPT)

- Coordinated medical evaluation, psycho-social assessments and treatment
- Hospital-based
- Training for medical professionals
- Coordination of training for other related disciplines

Children's Advocacy Centers (CAC)

- Coordinated DSS/DA/Law Enforcement investigation
- Forensic interviewing by trained professionals
- Case review and data collection
- Training for related professionals
- Referral to hospital–based Child Protection Team for medical evaluation, psycho-social assessment and treatment

RECOMMENDATIONS

1. **Establish a Multi-Track System in Massachusetts to deal differentially with more serious and less serious cases of abuse and neglect.**

   Low risk DSS cases, screened-out reports and cases deemed unsubstantiated after investigation would be addressed more appropriately by referral to community-based family support collaboratives. There family support coordinators and Family Support Teams would be available to assist families in identifying needed services from among a range of local resources. This triaging would address for the first time the high percentage of families and children reported to DSS who are screened-out without services. It would reduce DSS involvement in less serious cases, allowing the Department to use its resources efficiently on more serious child protection issues.

   Moderately serious cases would be referred to the DSS Multidisciplinary Assessment Teams (MDATs) where DSS workers and community professionals would work together to assess cases, address child placement issues, develop service plans, and link families to specific services.

   The most serious cases, including those involving the courts, would be referred by DSS to local Children's Advocacy Centers. There the child and family would benefit from multidisciplinary assessments, including forensic interviewing and psychosocial evaluations. Treatment and case management services would also be provided. Referrals would be made for specialized medical evaluations through hospital-based Child Protection Teams working in collaboration with CACs.

2. **Properly assess all cases entering the system and ensure families a central role in this process.**

   Assessment must be the first response of any quality child protection system. Without a solid understanding of the multiple and interacting issues confronting troubled families, case practice is undermined and cannot result in appropriate and effective service planning. All cases, irrespective of their level of presenting seriousness, would benefit from an assessment conducted by a CAC, a DSS-based MDAT, or by a Family Support Team in the community. Involving families directly in the process of assessing the issues and needs they face must be honored at every level.

3. **Make services available to all families who seek them, not only when a child is at risk of immediate harm.**

   Children and families must have access to services when concerns are of a less serious nature so that future harm can be prevented. A comprehensive and expanded family support system operating at the community level must be implemented in order for multi-tracking to succeed.

4. **Strongly encourage and adequately support collaboration among agencies and disciplines.**

   Collaboration among child protective services, law enforcement, medical providers and child welfare agencies should be coordinated centrally, through a statewide mandate, with sufficient resources, support, and quality assurance. The needs of children and families should be the driving force behind freer information sharing and collaboration among agencies and individuals.

5. **Support population-based funding among state agencies involved with meeting the multiple needs of abused/neglected children.**

   Services need to reflect the needs of the populations served. Linking parents and children to services that are available but that are not appropriate is grossly ineffective and wasteful. "Wrap-around services" typically will serve children by using funds from various agencies to better address identified needs.

6. **Incorporate within social worker training the skills to conduct strength-based assessments.**

   Workers must be trained to identify and nurture family strengths, rather than focusing primarily on family weaknesses. Even for professionals experienced in working with families, a reorientation about the appropriate roles for families and professionals must be included. The role of the professional in a community family support system can be transformed from that of director and producer of change to a resource and facilitator of change.[151]

CHAPTER 8

Multidisciplinary Assessment: The Core of Effective Practice

As we have seen, the problems associated with child abuse and neglect can be complex. Not only can abused or neglected children exhibit serious emotional and developmental impairments, their parents may also struggle with alcohol and drug dependencies, emotional disorders, lack of attachment with their children, and deficiencies in parenting skills and knowledge. Also, the physical signs of child abuse - bruises, broken bones, and other more subtle signs of non-accidental injuries - often require experienced medical experts to detect and confirm as abuse-related. **These situations are often so complex that no single professional or discipline should have the burden of assessing a family's full needs and developing a service plan to address them.**

All cases of abuse and neglect can benefit from a multidisciplinary team approach to medical diagnosis, assessment, investigation, and treatment. Studies show that in the most serious cases, sound clinical and prosecutorial outcomes are optimized when they are the result of comprehensive, up-front assessments of child victims, joint investigations, quality forensic interviewing techniques, and limitations in the number of child witness interviews.

Multidisciplinary teams are convened to assess a variety of issues including: medical evaluation, the extent of trauma inflicted on the child, the child's overall diagnostic and treatment needs, the indications for prosecution, the non-offending parent's position, and whether the offender is acknowledging or minimizing the abusive behavior. There is a growing consensus that the implications of placement decisions are so critical to the child that no one individual should have absolute discretion in this area. Teams can pool the collective wisdom and experience of their members and make sound judgments about contacts between offending parents and their children.

In court-involved cases, the use of teams provides greater likelihood that the abused child will have input into decisions concerning their needs. For example, one jurisdiction uses a written questionnaire to assist in determining parent offender/child victim contact after sexual abuse has been disclosed. It asks simply, "Are the child's needs being put forth *first*?" This child-centered approach ensures that children's needs are considered over potentially competing agency agendas or individual ideologies.[152]

Generically, Multidisciplinary Child Protection Teams (CPTs) are comprised of professionals from the medical, mental health, child welfare, and legal disciplines. The Teams are convened to evaluate the child's condition and safety and to implement a service plan to address the needs of the child and family.

A typical Team assessment includes a physical, psychosocial, and developmental evaluation of the child, as well as an assessment of the family's ability to function and provide a safe environment. The Team's first priority is to ensure the safety of the child. This could mean a recommendation to remove the child from the family or to provide a range of family services so that the child may remain safely at home. Trained legal professionals on the team determine if a crime has been committed and identify appropriate legal remedies available to protect the child from further harm.

The potential benefits of Multidisciplinary Child Protection Teams are numerous. They not only improve the quality of assessments, treatment plans, and services for abused and neglected children; parents, families, communities, and the child welfare system benefit as well. Research shows that multidisciplinary CPTs:

- Increase collaboration and cooperation among agencies;
- Broaden perspectives of involved professionals;
- Increase the number of reviewed cases;
- Decrease the number of cases that "fall through the cracks."

In addition, a study conducted by the California Attorney General's Office concluded that the quality assessments provided through the multidisciplinary approach expedite the legal process by decreasing the number of child interviews while increasing the findings of evidence of abuse.[153] Quality assessments, therefore, improve the probability of a successful prosecution in cases of sexual and serious physical abuse.

Teams have a number of potential benefits for communities, as well. These include: promoting community awareness and action with respect to abuse and neglect; increasing an understanding of community strengths and weaknesses; and, developing additional services and resources at the local and state levels.

Assessments can be best provided by permanent, community-based multidisciplinary teams that function under a statewide system that is itself based on consistent principles of practice and accountability. The following section describes such a system.

Child Protection Teams of Florida

The longest-standing and most successful system of child protection teams is in Florida. The enactment of Florida's child protection law in the early 1970's, and the substantial increases in reports of suspected child maltreatment that followed, prompted the state to create a system of diagnostic and treatment services for children and families who came to the state's attention through these reports.[154]

Under Florida statutes, child protective investigators were required to determine the cause of harm or threatened harm for each child, as well as the nature and extent of all injuries from abuse and neglect.[155] Child abuse investigators, however, were unable to access the resources necessary for such determinations. As a result, the Florida Department of Human Resources (DHRS), within which Child Protective Services is located, developed a method to provide specialized medical services to aid investigators in this responsibility. In 1978 the first Child Protection Team (CPT) was established in Jacksonville, Florida.[156]

This pilot program involved a team of child and family experts and an appointed pediatrician with a specialty in abuse and neglect. Together they provided comprehensive assessments, more accurate diagnoses, and appropriate treatment plans for affected children and families. The success of this team, funded through legislative appropriation, led to the development of CPTs in each of Florida's 15 districts that operate under the Department of Health.

Child sexual abuse reports dramatically increased in the early years of the CPTs operation. Soon CPTs, originally established to evaluate physical abuse and neglect, became specialized in the medical examinations of sexually abused children and the evaluation of sexual abuse accusations. This led to the awareness that many other sexually abused children did not have access to appropriate treatment and services. Thus, in 1984, the legislature funded child protective services to develop Florida's Sexual Abuse Treatment Program (SATP), a model intervention and treatment plan for child sexual abuse victims and their families that now also operates through funding by the Department of Health.

Although collaboration exists between the CPTs and SATPs, each program has a unique purpose and offers distinctive treatment options.[157] CPTs are prime examples of high functioning public/private partnerships. They are community-based and function independently as non-profit organizations, providing consultative services to Florida's state child protection agency. Teams are funded by state allocations which support core services, including interviews, case coordination, medical evaluations, psychosocial assessments, psychological assessments, expert testimony, and training.[158]

Children who have been reported to Florida's abuse hotline and have been accepted by Child Protective Services for assessment meet the criteria for CPT services. These usually include physically abused, sexually abused, or medically neglected children.

Currently, there are 23 teams that provide services 24 hours a day, seven days a week, in all areas of the state, as well as satellite locations for those teams serving large geographic regions.

CPTs function under the direction of a pediatrician with expertise in child abuse and neglect who serves as the medical director. Other consultant pediatricians work for the team either on a fee-for-service or contract basis. Some teams have Advanced Registered Nurse Practitioners (ARNP) that practice with a consultant pediatrician.

A Team Coordinator, usually a social worker or nurse, is responsible for the coordination of daily activities and supervision of social work. The Team also has Case Coordinators, who conduct individual casework and assessment activities. CPTs are actively involved in training other professionals to identify abuse.

CPTs have a licensed psychologist and a consulting attorney, either on staff or on contract. Depending on the particular case, other staff members may include school personnel, representatives from community agencies working with the child and family, or an attorney representing the state. Across Florida, current CPT staff include 133 physicians and ARNPs, 212 social workers as case coordinators, 14 nurses as case coordinators, 46 psychologists, and 18 consulting attorneys.[159]

Many CPTs are now located within the more recently established Children's Advocacy Centers and function in accordance with the National Standards of Children's Advocacy Centers. (A general description of CACs follows.) Though child welfare and child health professionals in Florida launched this system over twenty years ago, it has continued to evolve to meet newly identified needs. For example, when Florida recognized the need to reach rural areas with a shortage of trained professionals, they initiated a "telemedicine program." This program has significantly reduced the number of children needing transportation for evaluation, and has increased successful court actions by improving the medical expertise of local health professionals.[160]

Another example of how CPTs have evolved relates to the state's aggressive recruitment and training strategies for physicians. All medical personnel participating on these CPTs must complete a required training curriculum. The training encompasses classroom training and a requirement that the physician in training work with an experienced professional mentor prior to being deemed sufficiently experienced to evaluate and treat child abuse cases.

This basic training is supplemented with widely attended regional trainings held twice a year where medical staff consult with their colleagues on complex or unusually cases and learn about the latest advances in the field. These trainings are offered at no cost to the physician.

Consumer and Professional Responses to Florida's Program

Annual surveys conducted by the Children's Medical Service division of the Florida Department of Health have consistently found that the majority of children and families involved with Child Protection Teams are very satisfied with the quality of team services. Eighty-seven percent (87%) of participants rated the quality of team services "excellent or good."[161] Satisfaction among mandated reporters who interface with the teams was even higher.[162]

The role of Florida's CPTs in reducing subsequent child deaths from abuse and neglect is noteworthy. Data show that only three of the many thousands of children assessed by the Teams later died from abuse or neglect. (In one case, Child Protective Services did not follow the Team's recommendation that the child not be returned home.) In contrast, 68 child deaths occurred among children served by Child Protective Services who were not referred to the Teams.[163]

Florida's Child Protection Team Program provides assessments and evaluations by permanent community-based multidisciplinary child protection teams that function under a statewide system based on consistent principles of practice and accountability. The longevity and success of this child protection program makes it an exemplary model for evaluation and study by other states committed to implementing approaches that work.

By working creatively to identify multiple funding streams, CPTs in Florida have demonstrated that fiscal cost need not be barriers to quality assessments for abused, neglected and traumatized children. **Florida CPT's provided 19,142 children and their families with assessments in Fiscal Year 1997-98, at an average cost of $436 per assessment.**[164]

Massachusetts Teams

Currently, in the state there are different multidisciplinary team approaches operating in response to cases of child abuse and neglect - Sexual Abuse Investigative Network Teams (SAIN Teams), Children's Advocacy Centers (CACs), hospital-based Child Protection Teams (CPTs), and Multidisciplinary Assessment Teams (MDATs). The quality and availability of the teams vary widely across the state. They also differ greatly with respect to their specific goals, functions, structures and membership.

Overall, these teams do not make up a statewide, coordinated system with uniform standards and accountability to identify, assess, and treat child abuse victims as they enter the child protection agency. The existence of this basic infrastructure, however, makes it possible to envision the development of an effective, truly coordinated, statewide system.

Some counties are working to develop better coordination among their local teams, and legislation is pending to address the need for statewide Children's Advocacy Centers and to expand hospital-based Child Protection Teams. These important efforts and the recommendations described below could significantly upgrade Massachusetts' child protection response and result in more effective investigation, evaluation and treatment planning for children and families.

In describing the various teams operating in Massachusetts, there are a number of issues that are fundamental to the future functioning of all of them.

- *Confidentiality*
  Since multidisciplinary teams are specifically designed to cross professional barriers, issues of confidentiality among professionals who participate on these various teams must be formally addressed.

- *Training*
  Multidisciplinary teams must be supported through ongoing training programs aimed at enhancing professional skills, clarifying team roles, and supporting good team dynamics.

- *Decisions by the Courts*
  The assessments and recommendations made by multidisciplinary teams must be routinely shared with the courts as they formulate decisions on a range of service and placement issues involving abused and neglected children. This will better ensure decision making that is in children's best interests.

- *Services*
  Adequate funding of current effective services and the development of specific family supports and treatment options identified by the various teams are essential to the Teams' ability to develop and implement service plans that effectively meet the needs of children and their families.

Sexual Abuse Investigative Network Teams [SAIN TEAMS]

The Sexual Abuse Investigation Network (SAIN) program was developed in the early 1980's by DSS, District Attorney's Offices, and law enforcement, in an attempt to create a multidisciplinary approach to the investigation and assessment of child sexual abuse cases.

The complex nature of sexual abuse cases requires that various professionals be involved with the child and the family during investigations. In past years, the increased number of involved professionals often resulted in multiple interviews of children. To avoid the potential negative impact of multiple interviews, professionals developed the investigative process used by SAIN teams. It minimizes trauma for children and provides a more structured, systematic response.

The first SAIN teams in Massachusetts began in Springfield in the early 1980s.[165] By 1998, SAIN teams had been implemented in each of the 11 judicial districts of the state.[166] Most SAIN teams do provide support to investigators and to families. However, the main focus of these teams is interviewing child victims of sexual, and, in some counties, physical abuse. Even though there is no standardized model for this process, the interview procedure has been found to be similar across sites.[167]

Each SAIN team has a team coordinator responsible for scheduling team meetings, managing the SAIN process, assisting in the sharing of information, and functioning as a resource for other team members. Most teams have a separate forensic interviewer.

Teams consist of professionals from the District Attorney's Office, police, and child protective services. While professional disciplines within the team vary across counties, each team is typically comprised of a DSS investigator/supervisor, Assistant District Attorney, a Victim Witness Advocate, a professional from law enforcement, and a child interviewer. When needed, a physician is consulted regarding medical evidence, and some counties have mental health professionals that may consult with the team.

In cases of alleged abuse, pre-interview meetings are held to orient the team, plan the interview, and, if appropriate, gather information from parents. The child interview usually lasts from thirty to sixty minutes. The interview is typically carried out in a small, comfortable room with a one-way mirror. It may also be videotaped depending on the needs of the team. The one-way mirror and videotaped interview are essential, for they decrease the likelihood of the child having to be interviewed more than once.

Specialized interviewers with training and experience in child interviewing, forensics, and child safety conduct the majority of interviews. Other members of the team may occasionally conduct an interview if, for example, they have a better relationship with a child or are better "match" with a child, in terms of gender, culture, or style of interviewing.[168]

Cases that are eligible for SAIN services differ from team to team. Many teams have tried to create a written set of criteria to clarify what constitutes an appropriate referral. However, these criteria are not always written clearly and many are subject to interpretation. One frequent criterion is a required disclosure by the child or clear medical evidence that sexual abuse occurred. But it is very difficult to determine objectively what constitutes a disclosure, and even more taxing to understand the definition of "clear medical evidence."

DSS is the primary referral source for SAIN cases and participation is voluntary, based on parental consent. At present, DSS is attempting to standardize the criteria and is conducting a statewide survey and developing a reporting protocol.

Massachusetts SAIN teams clearly demonstrate many benefits.[169] SAIN teams:

- reduce the number of child interviews;
- reduce or eliminate inconsistencies resulting from multiple interviews;
- increase the consistency and clarity of investigation for families;
- help families access additional services;
- increase the overall quality of interviews and investigations;
- enable investigators to gather evidence more thoroughly because of information sharing;
- increase the tracking of cases;
- increase understanding of other service systems through training and mentoring programs.

These specialized teams could logically evolve into full-scale multidisciplinary assessment teams whose role would extend beyond the forensic interview. Today, several former SAIN teams have, in fact, evolved into full-scale Children's Advocacy Centers (described more fully below). Within this model, children who have been referred because of allegations of serious physical abuse or neglect have the advantage of a forensic, clinical, and medical assessment, as well as follow-up clinical support and case management. The trend to evolve SAIN teams into a statewide system of Children's Advocacy Centers must be supported and encouraged.

Children's Advocacy Centers [CACs]

The National Children's Advocacy Center (CAC) Model was first developed in Huntsville, Alabama in 1985. This model was designed as a multidisciplinary program independent of the major state agencies involved in child abuse investigations.[170] It is similar in purposes to other multidisciplinary approaches, such as the Florida Child Protection Teams and the Massachusetts SAIN teams described above that have expanded their role.

The purpose of the Children's Advocacy Center model is:

1. To facilitate collaborative investigations of suspected child abuse;
2. To decrease the trauma associated with multiple interviews of the child; and,
3. To provide supplementary services to abused children and their families.[171]

The response to child abuse allegations includes forensic interviews, medical evaluation and referral for therapeutic intervention, victim support and advocacy, case review and case tracking. These components may be provided by the CAC staff or by other members of the multidisciplinary team.

Ideally, CACs are governed by a non-profit board of directors and are located in independent physical facilities where interviews are conducted in specially designed child-friendly environments.[172] Unlike SAIN teams that limit their interventions to child victims of alleged abuse, CACs have been designed to extend their services to non-offending family members of the alleged victim. While SAIN teams were created to deal specifically with sexual abuse, CACs are involved in serious physical abuse and neglect, as well.

The core staff of a CAC typically consists of a coordinator, mental health consultant and trained volunteers who assist in the day-to-day operations of the center.[173] CAC staff is also involved in the coordination of the teams, and in providing follow-up and coordination of training for the team members.

The Nation Children's Alliance, a non-profit organization committed to the establishment and improvement of Children's Advocacy Centers, has identified the following components necessary for full membership in the Alliance.

- A child-appropriate facility
- Organizational capacity
- Cultural competency and diversity
- Forensic Interviews
- Multidisciplinary Teams that include members from:
  - law enforcement
  - child protective services
  - prosecution
  - mental health
  - victim advocacy
  - Children's Advocacy Center

CACs are designed to accommodate the special needs of the community and in this way, each CAC is unique, with varying components. CACs that seek full-membership in the Alliance work towards implementing all of the required components listed above. Within this range of diversity, however, all programs share a common philosophy:[174]

- Child abuse is recognized as a community problem. No single agency, individual, or discipline possesses the required knowledge, skills, or resources to provide comprehensive assistance to abused children and their families.
- Interventions in child abuse cases must be sensitive to the needs of abused children and their families and these needs must be addressed in a respectful environment.
- Collaboration among the various disciplines that comprise the child protection system will result in a more thorough understanding of cases, and in the most appropriate responses available.

Children involved in allegations of sexual abuse, serious physical abuse, or siblings of children who have died from abuse, are eligible for CAC services. Though DSS is the primary referral source for CAC cases in Massachusetts, referrals are also made by other agencies, including police, hospitals, mental health agencies, and school departments.[175]

There are several advantages to the CAC design according to the Final Report of the Multidisciplinary Task Force convened in 1995 by DSS to review models of multidisciplinary team practice.[176] By creating a child-friendly environment located in a site not associated with any one agency, CACs create a less traumatic atmosphere for the child. This setting also minimizes family members' negative impressions of the child protection system and provides them with a single point of entry to services provided by various systems involved with the CAC.

The CAC's ability to provide a coordinated and collaborative response is founded on interagency agreements and so its success depends on each agency's continued ability and willingness to participate and meet commitments. Another factor that affects the CAC's success is its ability to acquire adequate funding for its site and for the provision of services.[177]

In 1994, the Suffolk County Task Force began designing the first Children's Advocacy Center in Massachusetts to replace its existing SAIN team.[178] In addition to Suffolk County, there are established centers in Middlesex, Hampden, and Berkshire Counties. Centers are under way in Norfolk, Plymouth, Franklin-Hampshire and Barnstable Counties. Some existing SAIN Teams, such as the one in Essex County, have now expanded their teams to include physical abuse.

Referrals to these multidisciplinary teams have increased dramatically over the past decade, a clear indication of the need for expanded capabilities within these centers.

Hospital-based Child Protection Teams (CPTs)

Hospitals and emergency rooms are frequently the first to identify children who have been the victims of physical abuse, sexual abuse and serious neglect. Since the 1970s, hospitals have understood the need to establish internal systems to address the various needs of these children and their families. Hospital-based Child Protection Teams were initially established to bring together medical specialists and hospital social workers to develop appropriate responses to these cases. State child protective workers became regular members of some of these teams and all worked together to contribute to an appropriate service and treatment plan. In Massachusetts, the earliest CPTs in hospitals were developed at Boston City Hospital and at Children's Hospital in the late 1960s.

A recent survey conducted by Massachusetts Citizens for Children of recognized experts in child abuse found that **statewide there are fewer than ten physicians who identify themselves or are recognized by their peers as experts in child abuse and neglect**.[179] It is alarming that in a state recognized as a leading center for expert pediatric medical care, the number of trained child abuse specialists is so low. In contrast, through its statewide, comprehensive system of Child Protection Teams, Florida and its courts recognize 133 such experts while its population base is only one-third larger than Massachusetts.

Hospital emergency room staff, family practitioners, pediatricians, and other specialists treating children are literally lifelines for children who present with injuries and symptoms resulting from abuse and neglect. Failure to recognize non-accidental injuries and to report suspected child abuse cases has cut the lifelines of too many Massachusetts children who are sent home only to return to hospitals dead, dying, or seriously injured.

The major reason for the failure to attract physicians to this important work is economic. Currently hospital-based CPTs operate on woefully inadequate budgets. These multidisciplinary teams generate very little income for the hospital, and in today's fiscal environment, hospitals are not inclined to underwrite budgets for the teams to the degree needed.

In contrast to Florida, the state legislature has appropriated no funds for this activity, and DSS has no funds within its budget to support this. Consequently, the medical component of most reported cases of child maltreatment is omitted. There are no Fellowships at any Massachusetts hospitals to train the next generation of child abuse specialists. Currently, of the six pediatric specialists in Massachusetts, one is over 65 years of age, one is in his late 50s, and the rest can only do this work on a part-time basis. Also, no support for organized research about child maltreatment exists, despite the fact that over 100,000 cases are reported each year.

The shortage of child abuse experts within medical settings is further compounded by a lack of formal supports for new physicians coming into this field. Without it, physicians interested in child abuse quickly become overwhelmed and discouraged. For example, at Baystate Medical Center in Springfield a resident physician who developed expertise in this area soon became inundated with referrals. During this physician's tenure of less than a year, referrals from various departments in the hospital increased dramatically. Without an adequate number of other child abuse specialists to help evaluate cases, the physician eventually left the specialty, physically overwhelmed and emotionally drained.[180]

Clearly, physicians need a structured support network they can turn to for consultation around complex cases and where they can gain the emotional support they require. Massachusetts must move quickly to establish and fund a statewide system of hospital-based Child Protection Teams and support the development of a statewide training and fellowship program that would aggressively sponsor, recruit and support physicians to work in this vital area.

Teaching hospitals for children have been shortchanged under federal policies for underwriting the training of physicians. Graduate programs for medical doctors are subsidized primarily through the Medicare health care program for the elderly. Since pediatric centers treat young children, they receive few benefits.[181] For example, the average independent children's hospital receives about $400 federal dollars per resident physician while the average adult hospital receives $87,000 per resident.[182]

All pediatric hospitals in Massachusetts are attempting to cut costs and improve fund-raising in response to huge fiscal losses.[183] This situation could be turned around through a $285 million dollar proposal in Congress to fund children's hospitals. This critical federal aid would allow hospitals such as the Floating Hospital for Children, Massachusetts General Hospital for Children, the Pediatric Department of Boston Medical Center, Children's Hospital, and others across the state to move beyond their current level of service, and expand critical help for abused and neglected children.

Multidisciplinary Assessment Teams [MDATS]

The MDATs are Massachusetts' most recently implemented type of multidisciplinary teams, and are convened by the Department of Social Services. Initially piloted in January 1997, MDATs are currently operational in the 28 DSS Area Offices.[184] Their stated purpose in 1997 was to:

1. Collect comprehensive clinical information and improve understanding of the family and its needs;

2. Work directly with the family and child and develop recommendations to serve as the basis for a relevant and appropriate service plan; and,

3. Facilitate referrals to community-based services and communication between DSS and community agencies. (Note: This precedes implementation of Family Based Services Treatment Teams within DSS that began in 1999.)

Long-term goals of MDATs as described by DSS are to improve DSS decision-making early in the case, reduce the time a case remains open, decrease the number of children in out-of-home and multiple placements, reduce the rate of families re-entering the protective service system, and encourage community-based providers to participate more actively with DSS in serving children and at-risk families.

MDATs in Theory

In theory, each MDAT is assigned a DSS team convener, who is responsible for scheduling and organizing meetings, facilitating Team discussions, distributing case materials, and preparing final assessment reports.[185]

Teams are ideally composed of standing members who meet on a regular basis and represent a variety of disciplines. Core DSS members may include a Team Convener, Social Worker, Assessment Unit Supervisor, and Domestic Violence Specialist. External members might include, a Substance Abuse Specialist, Mental Health/Trauma Specialist, and a Pediatrician or health care practitioner.[186]

In addition to its core members, MDATs can seek assistance from other community specialists in specific cases, e.g. a dentist might participate in a case involving serious dental neglect. Team members are meant to play an active rather than consultative role in assessing families and facilitating services.

During the Initial Investigation/Assessment phase of the case, the MDAT could be called upon to serve:

- Children with 6 "highs" on the Risk Factor Matrix who are living at home;
- Children with 10 "unknowns" on the Matrix at the conclusion of the investigation;
- Families whose cases are closed and then re-opened within 6 months; or
- Sexual abuse cases, or those involving juvenile sex offenders.

The "highs" and "unknowns" described above are derived from the Risk Factor Matrix used by DSS social workers to determine if a child is at risk.[187] Questions on the matrix are divided into categories: Child Characteristics, Child/Caretaker Relationship, and Caretaker Characteristics. For each question, the social worker making the assessment evaluates the child's status as no risk, low risk, moderate risk, high risk, or unknown risk. Once the level of risk has been assigned for each question, the social worker determines the overall level of risk, and, if necessary, refers the child to services.

Cases involving MDATs at the Ongoing Case Management phase might include:

- Children with multiple placements (over 3 placements within 6 months);
- Families who have multiple 51As filed;
- Children re-entering care after a return home within 6 months; or
- Cases that are chronically "stuck."

MDATs in Practice

While the theoretical premise of MDATs is appealing, an evaluation of currently operating MDATs demonstrates that many are still striving to fulfill their envisioned goals. When MDATs were originally implemented, a five-stage evaluation was planned to monitor the development, progress, outcomes, and impact of these Teams. The most recent analysis of this evaluation, entitled "Phase Two" was written in

November 1998 and provides insight into how the MDATs were functioning after one year of operation.[188] Responses to anonymous surveys developed and distributed by DSS and completed by Team members, highlighted benefits, as well as areas that needed development.

Sixty five percent of respondents had been on their team for at least 10 months.[189] Although this percentage indicates length of membership, it does not demonstrate the quality or level of active participation of each member. In other words, it does not distinguish between those members who regularly and consistently attend meetings and those who do not.

Consistent with our discussion above about the lack of pediatric child abuse specialists, the evaluation revealed that few physicians or other health experts were members of MDATs.[190] Lack of funding has been cited as the reason. Although in a few instances, local MDATS have chosen to use flexible funds to support the participation of key medical representatives, there is currently no statewide mechanism in place to fund medical professionals for these teams. Given that most cases reviewed by the MDATs involve moderately to severe abuse or neglect with medical implications, the lack of input from specialized health experts with experience in diagnosing and treating child maltreatment is alarming.

Benefits cited by team members during the evaluation include increased collaboration among a variety of experts, increased collaboration between DSS and service agencies, and increased availability of flexible funds needed to provide creative services to families. Criticisms of the MDATs were that the amount of time required to participate was significant and more than had been anticipated. Many professionals cannot remain on teams where compensation does not adequately match the time and resources necessary for their attendance. Also, 51 percent felt they received too little follow-up information on the cases reviewed.

Half of the "Phase Two" survey respondents indicated that they rarely or never saw the child and family being discussed.[191] Since the quality of any review is highly influenced by direct contact with the family and child in question, some argue that the MDATs are mostly consultative to the DSS social worker and do not conduct true "assessments."

A recent DSS survey of the kinds of cases being reviewed by ten MDATs makes it clear that a majority of cases being referred have been in the system for some time. These include: families with complex, interacting problems, e.g. domestic violence, substance abuse, serious mental illness; children with multiple 51A reports; children with multiple placements within a short period of time; children re-entering care within 6 months of returning home; and, chronically "stuck" cases. Though there is certainly value to providing input on difficult cases, it appears that the original purpose of the teams to review cases "up-front" and early is not its prime focus.

The need to conduct quality multidisciplinary assessments at the *earliest* stages of a case is a theme that has been consistently promoted by MCC since its Settlement Agreement with DSS in the mid-80s. As part of their separate investigations into the functioning of DSS, both the Senate and the House Committees on Post Audit and Oversight have embraced the notion of multidisciplinary teams and assessments.[192]

BEST COPY AVAILABLE

A central recommendation of the 1993 **Governor's Commission Report on Foster Care**[193] called for "front-loading" the system, that is, to focus the bulk of resources at the front end of the system when cases are just entering and a quality assessment of the child's and family's needs are essential. The rationale is that if cases are properly assessed and addressed early on they will likely move through and away from the system faster, benefiting the child, family, and the state agency. Such early and comprehensive assessments, it is argued, would minimize poor decision-making that may contribute to cases being "stuck" and those cases that revolve in and out of the system. The need for quality multidisciplinary assessment conducted early on in a case was a prominent recommendation reiterated throughout the Summit's recent proceedings.

MDATs and Family Based Services Treatment Teams (FBSTs)

In 1999, DSS began to implement a Family Based Services model combining multidisciplinary practice and family strengthening principles within a managed care system. In this model, established child welfare agencies compete to serve as the Family Based Service Lead Agency in their particular area of the state. Through local FBS Treatment Teams, Lead Agencies provide services to DSS clients from an array of local services. Increased family input in choosing appropriate services, and increased use of community supports for families are key to this program. Local, culturally competent experts in child development, substance abuse and other clinical issues can be made available to the network.

Currently, every DSS Area Office utilizes Family Based Services. Open DSS cases are served, as well as cases involving Children In Need of Services (CHINS) referred by the courts.

According to DSS, the roles of these two evolving team models is differentiated in the following way:

- MDATs provide a better understanding of a family and their issues resulting in a comprehensive clinical *assessment*, whereas
- FBS Treatment Teams provide a family-centered *treatment plan* following a completed assessment, as well as *access to wrap-around services*.[194]

These models represent the beginnings of an infrastructure within DSS based on family support principles and multidisciplinary practice. Their development should be supported. However, as these team models evolve, a clearer distinction should be made between the development of a service plan and its subsequent implementation. MDATs are better positioned to assess the child and family, and based on their assessments, to *develop* a detailed treatment plan. FBS Teams can best *implement* the treatment plan by creatively utilizing community contacts and flexible funding.

Dividing the roles of these two teams in such a way has important benefits for children and families. The clinical composition of a fully developed MDAT ensures that the treatment plan is tailored to the specific needs identified in the clinical assessment. The MDATs are also not constrained by managed care considerations as they develop treatment plans. In contrast, FBSTs are more limited in their clinical expertise and by their very design are meant to function as agents of the managed

BEST COPY AVAILABLE

care system. This has direct implications for families and the types of services they receive.

For example, an MDAT recommendation could include providing parent aide services to a neglectful mother. Parent aide services by design are based on the development of a relationship between the parent aide and the parent and may take from three to six months to establish. Important gains are often made in the period after the relationship is formed and trust has been built. If an FBS Treatment Team accepts the MDAT's recommendation for this specific service but limits the duration to three months, it will negate the basic philosophy of this lay therapy approach, thus rendering the entire intervention ineffective.

Recommended treatment plans that are not implemented in full, or services that are provided for a shorter duration than recommended can have dire consequences: service plans fail, parents working in good faith to improve their care taking skills are further stressed, state dollars are wasted, and children remain at risk.

Currently, many workers are reluctant to bring a case to the MDATs because they will need to present it a second time to an FBS Treatment Team in order to obtain services for their clients. Their clients may also have to meet with both teams. This is an inefficient use of limited caseworker resources and discourages families from participating in what they see as a redundant process.

While the functions of these two teams should be distinct and clear, information sharing and coordination between them is essential. Identifying a representative of the FBS Treatment Team to serve as a core member of each MDAT and to act as a liaison would be an ideal way to achieve this.

Family Support Teams

As discussed earlier, DSS cases identified as low risk, cases screened out without any investigation, or those found not to be substantiated after investigation could benefit from Family Support Teams that could coordinate family conferencing and "assessments" at the local level. Family Support Teams that include community-based social workers and other child and family service providers assist the family in identifying local supports that could reduce stresses and improve family life. In this model, parents play a key role in identifying their needs and the supports that would be most helpful in addressing them. Some local DSS offices are introducing the concept of Family Support Teams through "Community Connections," their community-based partnership program. A further description of this program is included in Chapter 16.

Multidisciplinary Assessments and the Courts

The impact of quality assessments on the handling of child abuse cases by the courts can be significant because these assessments are seen as highly reliable and accurate. For example, *Florida CPT cases referred to the courts have an 89 percent rate of conviction or pleas, while the rate of non-teamed cases is only 69 percent.* This higher rate reflects the CPTs' ability to properly send only the most appropriate cases to the court for its review, thus reducing court costs. In addition, data show that *Florida courts order 94 percent of recommendations made by CPTs, whereas only 53 percent of services are ordered when recommended by child protective service workers without the benefit of a team assessment.*[195]

It is clear that the quality of judges' decisions in complex matters involving children and families is inextricably tied to the quality of the information they receive. Massachusetts courts and the children they serve could benefit greatly from assessments and recommendations made by multidisciplinary teams. A discussion of this proposal is found in Chapter 13, "Abused/Neglected Children and the Courts."

RECOMMENDATIONS

Children's Advocacy Centers

1. **Enact legislation to support a statewide system of Children's Advocacy Centers.**

   To provide comprehensive and coordinated assessments of children and families involved in serious cases of child abuse and neglect, a statewide system of Children's Advocacy Centers must be established and funded. These Centers should be located in every county and in sub-county sites based on population and the distribution of child abuse and neglect cases.

2. **Include relevant disciplines within CACs.**

   Assessments conducted through CACs should involve all relevant disciplines including: health, mental health, DSS, the District Attorneys, law enforcement, victim advocates, as well as, family violence specialists, educators, and others when indicated. Quality forensic interviewing by trained law enforcement or mental health professionals should be a core component of CACs. Medical evaluations by pediatricians or nurses trained in child abuse and neglect diagnosis and treatment should also be a core component of the CAC system. Development of statewide emergency response protocols for after-hours assessments should also be developed.

3. **Reflect local community preferences when locating sites for CACs.**

   Though the National Alliance Standards promote the location of CACs as independent, non-profit entities governed by community boards, they also state that CAC location should reflect the preferences of the community. Some CACs operate under the auspices of a District Attorney's Office or as a specialized unit within or on the grounds of a hospital. Drawbacks associated with these settings, however, may include too narrow a focus on cases involving prosecution and the high overhead costs associated with hospital sites. Decisions about CAC location should be determined jointly through a process involving law enforcement, medical, child protection, and community leaders. A major goal is to ensure a setting that will provide clients with the greatest level of comfort.

4. **Standardize referral criteria to the CACs.**

   CAC legislation must define the specific types of cases that should be referred to the CACs for assessment and referral to treatment. Cases involving the courts and other serious cases of abuse and neglect should be the prime focus of the CACs. Referrals from the child protection agency and law enforcement should conform to these standardized referral criteria.

5. **Provide case management, review, data collection, tracking and outcome measures within CACs.**

   In addition to the function of assessing cases, CACs must provide case management and case tracking services or coordinate this function with other identified agencies. In addition, periodic case reviews and evaluation of outcome measures are essential to ensure effective response to child abuse victims.

6. **Develop training protocols.**

   The CACs should work in conjunction with the Departments of Social Services, the District Attorneys, boards of registration, and other accrediting bodies, to develop training protocols for all relevant disciplines, for example, law enforcement and forensic interviewers engaged in investigating cases of child abuse and neglect. The CACs and hospital-based Child Protection Teams should join in coordinating and providing training for other relevant disciplines, e.g. social workers and mental health professionals.

Hospital-Based Child Protection Teams

1. **Enact legislation to support a statewide system of hospital-based Child Protection Teams.**

   These CPTs should be established initially within medical teaching institutions located regionally across the state. Each CPT should include core staff including, at a minimum, a pediatrician, a psychologist, and a social worker who are trained to medically evaluate and treat children who have been abused and their families. Consultation on a 24-hour availability to other hospitals in the region ands to other rural medical sites would also be included.

2. **Create and fund a statewide medical training program to recruit, train and support pediatricians, nurses and other relevant medical providers to become child abuse and neglect specialists.**

   In addition to training medical personnel, the hospital-based Child Protection Teams should join with the CACs in coordinating training for other relevant disciplines e.g. mental health professionals, social services staff, law enforcement personnel, teachers, and other human service workers. Furthermore, Fellowships in Child Maltreatment must be established within the CPTs and supported with state funds to replenish the dwindling supply of child abuse specialists in Massachusetts.

Multidisciplinary Assessment Teams (MDATs)

1. **Ensure quality and effectiveness of MDATs within DSS.**

   Core standards for MDAT composition and team member participation should be implemented to improve quality assessments, decision-making, and service planning for children and families. Each family deserves the right to a quality, comprehensive review of their case.

2. **Include professionals with a wide range of competencies to serve on MDATs and provide a mechanism for reimbursement of selected specialists.**

   MDATs could be improved by increasing the number of disciplines represented on each team, particularly medical and educational experts. A funding mechanism must be developed to ensure the participation of these core members and other specialists when needed.

3. **Conduct assessments when cases are *first* opened.**

   MDAT resources should be focused more on "front-end" assessment of cases, than on cases that are "stuck" in the system. Bringing in MDATs at the onset of a case could improve service plans, assist DSS in making decisions regarding removal of children from their homes, and, over time, improve outcomes for children and families.

4. **Define the role of Family Based Service Treatment Teams to implement service plans developed by the MDATs and based on MDATs assessments.**

   Clinical assessments and treatment planning are two functions that should be vested in the MDATs. The FBS Treatment Teams' role should be to implement the service plan creatively through community contacts and flexible funding.

5. **Identify a representative of the Family Based Services Treatment Team to serve as a core member on each MDAT.**

   In order to facilitate information sharing, avoid redundancy and coordinate treatment planning and implementation, a liaison from the FBS Treatment Team should serve as a core member of the MDAT.

6. **Include families and their advocates in MDAT meetings whenever possible.**

   Involving families proactively in decision making about their children's future should be a core goal of each review. Families are often best able to identify their needs and the range of services that would best meet them. Family support principles that respect family input and that work to reduce or eliminate adversarial relations should be embraced at all levels of child protective services.

7. **Provide Team Members with regular and ongoing training.**

   DSS should provide ongoing multidisciplinary training opportunities for MDAT members, including psychosocial implications of abuse and neglect, medical consequences, and the effects of abuse and trauma on school behavior and performance. Team Conveners should be brought together regularly to share information and address barriers to good team functioning. Strategies to resolve contradictory opinions of participating professionals must be developed.

CHAPTER 9

Workforce and Workload: The Foundation of Quality Child Protection

Workforce and Workload

The prerequisite condition to the success of any meaningful changes in our state's system of child protective services is an adequate number of well-trained and highly skilled social workers. Any proposed changes in policy, organization, structure, and practice must be evaluated in the context of whether they will result in substantial improvement in staffing capacity at the front line. This improved staffing capacity must include investigation workers, case managers responsible for ongoing cases, and those overseeing the foster care and adoption process.[196]

Frequent calls to improve the quality of child protection investigations have been made over the years as well. Whether adopting better standards, adding multidisciplinary capacity to assessments, or moving toward multi-tracking, **any improvements are likely to be limited unless adequate staffing is concurrently achieved.**

In the past, licensing and organizational management have often been substituted for this systemic commitment to proper staffing. As the 1993 Governor's Commission Report stated: "So long as that situation persists (poor staffing which places children at risk), any policy, managerial, or structural amelioratives will be doomed to fail."[197] To change these outcomes, Massachusetts must do whatever is necessary to stabilize the staff assigned to our most at-risk children.

Salaries and Staff Turnover

The call to increase salaries that reflect the responsibility and risks of the job, and that compensate for the increased demands for licensing, has not been acted upon. Other states have recognized child protective service staff as highly valued state employees and have raised compensation levels accordingly. Starting salaries for bachelor level staff in Rhode Island and Connecticut are $10,000 *higher* than in Massachusetts. Even within our state, daycare licensors for the Office of Child Care Services receive a higher salary than DSS social workers though their degree requirements, licensing requirements, and level of responsibility, are significantly below those of DSS social workers.

The Department of Social Services currently pays incoming DSS workers *the same level of pay, whether or not they have a Bachelors or Masters degree*. This is not conducive to the recruitment of Masters level social workers, and not consistent with good business practice that motivates workers to attain higher levels of education and rewards them with increased compensation.

While the entry-level salary for all DSS social workers needs to be raised significantly, the Commonwealth should also incorporate a reward system similar to incentives being considered for teachers or those that currently exist for police. This would demonstrate a commitment to maintaining and rewarding staff for their ongoing training and professional development. It would also address the salary inequity described above.

In the current economy, inadequate salary for DSS workers is becoming an even greater factor in the high staff turnover. Seasoned workers with years of seniority, and also newer employees, are leaving the field to take substantially higher salaries in unrelated fields. One veteran DSS Supervisor recently reported that of the five employees he supervises, three have less than six months of experience. This is a startling example of how unstable the child protection workforce has become.

Incentives, such as more paid educational leave and better career development opportunities, could help retain competent staff. Consistent, high quality, and supportive supervision to frontline staff is equally critical to maintaining a stable and experienced workforce. In addition to case review, this supervision must include emotional support and adequate political protection to these workers.

Caseloads

It is clear that any meaningful system reform must address the caseload issue. Taking into account the complexity of cases, an optimum caseload size for a worker should be established. The Child Welfare League of America recommends that caseload standards for "initial assessments should involve *not more than 12 active reports*" and that "ongoing services to families opened for services and support after the assessment should involve *no more than 17 active families*, assuming the rate of new families assigned is no more than one for every six open families".[198]

The Commonwealth and DSS have for years stated their commitment to a caseload average of 18. However, numerous independent evaluations of this commitment, including four legislative commissions and three arbitrations, have recorded that *far too many social workers still routinely carry responsibility for 20 or more cases*. This failure to adhere to a professional standard not only contributes to burnout and staff turnover; it results in a lowering of casework quality and, therefore, in an increase of risk to children.

Lower caseloads, quality supervision, and higher, stable staffing standards translate into higher costs for service delivery, but such changes are essential to achieving substantial improvements in the quality of service to vulnerable children and their families. To improve the system, resources must either be expanded to meet the standards, or demands for service must be reduced to match the resources. Supporting a reduction in standards or an increase in caseloads in order to manage costs are not acceptable remedies.

Over the years, it has been the practice to dismiss as impractical calls for improved staffing and lower caseloads. Calls for reduced caseloads by workers and their Union representatives have been perceived as self-serving. Ignored is the tangible, and often devastating impact these operational deficiencies have on the children who must depend on the state for their well-being, protection, and in some cases, their basic survival.

Education, Recruitment and Training

Partnerships between the Department of Social Services and the schools of social work in Massachusetts state and private colleges are weak, and strategies for the development of social service curricula are lacking. Schools of social work do not stress the development of child protective service curriculum and there is little demand from students since salaries in child protective services are not competitive with social worker positions in other settings.

Efforts to recruit quality child protective staff, therefore, are hampered by lack of an available pool of graduating students from qualified academic programs. Currently, the workers at the Department of Social Services are drawn from a variety of Bachelors level programs. A notable percentage includes graduates of Bachelors level social work programs while the rest include those who majored in psychology, sociology or a similar social science.

Bachelor level training has long been viewed as appropriate for service in the Department. While this may be more practical, we believe these individuals should at least have been exposed to programs that focus on child welfare practice and that include field practicum. Accordingly, the bachelors level training best suited is the Bachelors in Social Work, which includes senior year fieldwork, as well as other field experience. Another is the Bachelors in Human Services available through the Springfield College of Human Services that attracts older students already exposed to the human service field.

Current DSS core job preparation includes a one-month pre-service training, four days per week of classroom instruction, and one day per week of field experience. A new worker shadows an experienced worker for several weeks. Specialized trainings for job functions, such as the nine-day curriculum for investigation and the five-day supervisor training, are available.

In-service training consists of approximately 48 workshops and 8 trainings in each of the six DSS regions staggered to "attract" as wide an audience of social workers as possible. The in-service trainings are not mandatory. Given current workload demands, many choose not to participate, especially if trainings are held across the state and require lengthy travel. Since the workshops cover such critical issues as posttraumatic stress syndrome, concurrent planning, substance abuse treatment, etc., failure to attend can hamper the abilities of social workers to identify the needs of the population they serve.

Reducing caseloads is essential if workers are to participate in these important trainings. The level of staff participation would also increase if expectations or standards regarding participation in ongoing trainings were incorporated into performance reviews.

Child Protective Services Training Institute

Through an expanded and reorganized DSS Training Program or Child Protective Services Institute, the Department could confer its own certification that the workers and supervisors it trains are qualified to carry out the full range of child protective services duties and responsibilities. Establishing this standard of practice is especially important to address the acute shortage of workers within child protective services who have completed either a Bachelors or Masters of Social Work degree.

Under this Child Protective Services Institute, all newly hired staff would be required to complete a two-year curriculum, which would include a comprehensive sequence of courses. Supervisors would complete an additional one-year curriculum in child protective supervision. Each worker would be required to pass a certification examination at the end of the course work. Newly hired staff would participate in an initial six-month mentoring program and be assigned to "shadow" or work side-by-side with an experienced protective services worker. During this internship period, new staff would not assume any decision-making roles.

Linking training and performance measures to annual evaluations and promotions would be central. Also, time and support must be built into job functions so that workers and supervisors could avail themselves of training opportunities without compromising their ability to handle their caseloads.

Licensing of Social Workers

The call for increased staff certification, licensing and advanced training was also made in the 1993 **Governor's Commission on Foster Care Report**.[199] Though licensing and certification have become a reality since then, these still require modification.

The licensure of DSS workers must be adjusted. Currently, the vast majority is licensed under the social work licensing law, Massachusetts Board of Registration of Social Workers Rules and Regulations CMR *258-12.00*[200] despite the fact that a large percentage of these workers have no formal social work training at all. This State law mandating that DSS workers be licensed was passed in the late 90s. Workers without advanced social work degrees were subsequently licensed as either licensed social workers (LSW), or licensed social work associates (LSWA). The LSW requires either a Bachelor degree in Social Work (BSW), a Bachelor degree (BA) in another field and two years of work supervised by a masters-level social worker, or a high school diploma and eight years of supervised experience. The LSWA requires a Bachelor degree or an Associates Degree (AA) in human services.

The "scope of practice" for these license levels actually prohibits the holder of the license from performing many of the necessary functions carried out by DSS workers. Stated simply, *these licensees are often functioning beyond the scope of their licenses*. These licensing standards are not understood, either by the public or the families who receive services from the Department. Most often, clients of the Department simply assume that their workers are trained and qualified "social workers."

RECOMMENDATIONS

1. **Increase the salaries of DSS workers to reflect the responsibility and risks of the job.**

   An inadequate commitment to a strong and well-supported workforce over the years has been a central cause of the current crisis in protective services and of the collapse of so many reform initiatives proposed over the last twenty years. New policies, administrative strategies, and service models alone will not lead to improved services, unless their implementation includes an upgrading of staff and staff support. Adequate capacity is the foundation on which to rebuild the mandate, mission, and organizational structure of child protective services. It begins with compensation that fairly reflects the responsibility and risks of the job.

2. **Establish legislation to adopt caseload standards as promoted by the Child Welfare League of America.**

   Given the demanding role and functions of DSS caseworkers, caseload standards promoted by the Child Welfare League of America should be implemented.

3. **Tap into federal Title IV-E/B funding to develop graduate-level training for DSS staff.**

   Federal IV-E Funds should be used to expand the opportunities for Department staff to pursue graduate level training in social work, psychology or other related human service fields on a part-time or full-time basis. Time and support factors must be built into the job function so that workers can meet training requirements and opportunities. Currently DSS workers may avail themselves of opportunities to obtain a masters degree or other certification, however no mechanism is in place to provide support to the DSS office during the worker's absence. This places a burden on other workers and skews caseloads, creating a prohibitive environment for educational advancement.

4. **Establish staff reimbursements to support advanced training.**

   In order to support advanced training and degree qualification, reimbursement mechanisms should be established for DSS social workers, similar to those afforded police. This reimbursement program should be established either through legislation or administrative directive.

5. **Create a partnership between DSS and the Schools of Social Work to expand the pool of MSWs and BSWs for Child Protective Services.**

   To increase the recruitment of graduate level staff into the Department of Social Services, DSS and the Massachusetts-based Schools of Social Work, both public and private, should develop an active partnership to promote education in child protective service within current undergraduate and graduate social work training curricula. DSS and the Schools of Social Work should explore ways to use in-service training courses as credited courses towards a graduate degree in social work. Federal funding to support this partnership and the development of a model education curriculum should be sought through Title IV-E funds described above.

6. **Develop the current DSS training program into a full-fledged Child Protective Services Institute.**

   The current training program at DSS has been developed by highly qualified individuals, and, with additional support and creativity, could be expanded into an exemplary training opportunity for young professionals seeking careers in public service. This model of an internal worker-training institute has been successfully implemented in business, e.g. within banking, and it could serve as a new way for DSS to effectively meet the need for an experienced and competent workforce. The successful development of such a strategy would transform DSS into a respected provider of quality child protective services. The elements are in place for this bold move and the leadership and talent already exist within the Department to make it happen.

BEST COPY AVAILABLE

7. Adjust the licensure of DSS workers.

Currently, the vast majority of DSS front line workers are licensed under the social work licensing law, CMR 258, despite the fact that a large percentage of these workers have no formal social work training. The "scope of practice" for some of the law's license levels actually prohibits the holder of the license from performing many of the necessary functions carried out by DSS workers. As a result, these licensees are often functioning beyond the scope of their licenses.

CHAPTER 10

Abused and Neglected Children in Foster Care

Distressing statistics show that nationally over half a million children and youth were in state foster care systems in 1996.[201] Since 1997, there has been a 90 percent increase in American children in foster care while the number of licensed family foster homes has decreased.[202] Child welfare agencies find it increasingly difficult to recruit and retain foster homes. **There are barely 130,000 foster homes available at present,**[203] **and as many as 40 percent of foster families quit in their first year**.[204]

Massachusetts is far more likely than most other states to remove children from their homes. In July 1997, there were 11,957 Massachusetts children living in substitute care, e.g. foster homes, residential programs, or adolescent shelters.[205] In 1995, **65 of every 1,000 maltreated children were removed from their Massachusetts homes,** compared to 49 of every 1,000 in the nation as a whole.[206]

The reason these numbers are greater may be complex. They may represent an over-dependency on the use of foster care as a substitute for an array of family preservation and support services that could work to keep kids safe in their own homes. The lack of these services or the inability of protective service staff to locate and access them may be a factor.

On the other hand, Massachusetts' practice may simply reflect a stronger bias against keeping children in any home where the threat of future abuse or neglect may be present. The reasons for this conservative bias, if there is one, may be tied to the tremendous personal burden front line workers feel when they make decisions to leave children in homes that are less than ideal. DSS workers and their supervisors have often been held personally accountable for those decisions when children have been re-abused in those homes.

Multiple Placements

Multiple placements are perhaps the most serious problem facing children in foster care. In Massachusetts, **more than one-third of children in DSS foster care had experienced three or more placements in their lives**, according to a 1997 DSS report.[207] Some children and adolescents can experience dozens of placements while under DSS supervision. This is due largely to the very challenging problem of enough quality foster and group homes.

Studies document that particularly for younger children, multiple placements can have serious adverse consequences. One study, for example, confirmed that those who experienced more changes in caregivers during their early childhood were more likely to commit more serious crimes.[208]

The practice of placing children in multiple homes and settings is fundamentally indefensible. Children need safety but they also require stability and predictability in their lives if they are even to begin healing from the effects of their abuse or neglect. The constant disruptions these children are forced to face in their relationships with peers and adults and in their schools and environments would generate enormous stress in any normal adult with good coping skills.

State systems meant to protect children have a fundamental obligation, first and foremost, to "do no harm." Children must not be exposed to multiple placements and to the distress and psychological harm that caused one multiply placed 10-year-old to say "*I wanted to die, because if you die you don't have to start all over again..*"

Foster Home Supply

Clearly, the multiple placement problem could be reduced if there were an adequate supply of foster homes. Yet it is becoming increasingly difficult to locate families willing to care for children who have special needs and behavioral issues related to trauma.

A high profile DSS media campaign to recruit foster families and address the needs of severely traumatized children has had some success in recruiting new homes. The state has also contracted for services to support the special needs of foster parents so that crises can be managed effectively before they result in overwhelmed foster parents demanding immediate removal of a child from their home.

Despite these strides, however, **front line workers continue to report children missing school and being cared for throughout the day in DSS offices because no foster placements are available.** Homes for adolescents are particularly short in supply, leaving some workers with no choice but to place their teen clients in a string of one-night placements in emergency adolescent shelters. The stress precipitated by this constant instability and disruption results in many teens simply running from DSS care to the streets where they are vulnerable to drug and alcohol abuse, sexual victimization, and even more abuse and neglect. Clearly, these situations are untenable. Children must not be further traumatized by the very system mandated to serve and protect them.

Children Transitioning Out of Foster Care

The National Foster Care Awareness Project has found that 12 to 18 months after leaving foster care, 27 percent of male and 10 percent of females had been incarcerated, 37 percent had not finished high school, and 50 percent were unemployed.[209] Studies have also found that 30 percent of the nation's homeless population is comprised of former foster children.[210]

Clearly, the challenge of transitioning adolescents successfully out of foster care and into independent living must be met if we are to avoid these outcomes for them and our society. The special demands of adolescence often make these older children extremely difficult to place or adopt. However, social workers are often able to predict early - often by the time an adolescent reaches the age of 12 or 13 - what the chances will be for his or her adoption. For these teens, a permanent place to live is likely to be more appropriate than a series of temporary homes.

Federal guidelines under the John H. Chafee Foster Care Independence Care Program specifically state that funds may be used to identify teenagers who will probably "age-out" of the system and that specialized services may be targeted to teenagers who are as young as 13 or 14. These guidelines represent a paradigm shift in the way state workers can deal with these older children.

Many child advocates suggest that a "permanent" living arrangement for them can be identified, for example, a boarding school or other permanent group care model. This strategy would allow these children to remain in one stable environment and school for the duration of their teen years. The especially challenging adjustments that are a normal part of every teenager's life should not be compounded by the instability and psychological stress that result from numerous placements.

Timeliness of Placements

Children who are removed from their birth home must also have *timely* access to a permanent and safe home with a secure and loving family. The Adoption and Safe Families Act (AFSA) described earlier attempts to support children early on by establishing state requirements meant to prevent children from languishing in foster care year after year. Massachusetts must maintain data on the effect of these new federal and state mandates to ensure that children are, in practice, finding permanent placements as soon as possible.

RECOMMENDATIONS

1. **Reduce multiple placements of children in foster homes and residential settings.**

   Though the move to foster care for some children can be a lifeline to safety and the path to a stable and loving family, many children experience foster care as another source of instability, stress and disappointment. This is particularly true for children who experience the unpredictable disruptions of multiple placements. Multiple placements are the result of several factors, including foster home shortages in high demand areas and lack of round-the-clock supports for foster parents. DSS is working hard to address these issues and should be encouraged in its efforts to build a quality and stable foster care system. The reduction of multiple placements of children should be the goal that drives all foster care improvement efforts.

2. **Adequately fund and support relatives in caring for kin children.**

   Due to financial constraints, many relatives are unable to care for abused or neglected children of family members. Unless qualified for foster parent status, many simply cannot afford to care for a related child. The state is working to qualify more relatives as foster parents so these kin can receive financial support to ease the burden of caring for an extra child in their home. Additional supports, such as respite care and transportation assistance, could also help keep children with their kin.

3. **Expand the availability of foster homes, particularly specialized homes able to meet the needs of traumatized children.**

   To address the rapid increase in foster care and the serious shortage of qualified foster homes, Massachusetts should review and replicate successful strategies proposed by The Casey Family Program it its recent study.[211] Some of these include: clarifying roles and responsibilities for foster families, investing time to "match" children to homes, building collaborations among agencies recruiting these families, and supporting foster families to do their job well.

4. **Identify *young* adolescents likely to age out of foster care without adoption and provide them with early, permanent, and stable placements.**

   Federal guidelines under The Chaffee Act specifically state that funds many be used to identify teenagers who will likely age out of foster care without being adopted. Services may be targeted to teenagers as young as 13 or 14 years of age. Massachusetts must address the needs of these older children creatively by exploring boarding schools and other group care models that would ensure them a stable living arrangement.

5. **Ensure the successful transition to independence for *older* adolescents aging out of foster care.**

   Housing, skills development, education, and independent living programs must be implemented to address the pressing needs of abused, neglected and traumatized children who are growing older and "aging out" of foster care.

Again, Massachusetts must take advantage of the 1999 Foster Care Independence Act and the John H. Chafee Foster Care Independence Care Program to help these children develop the requisite skills to attain independence. To avoid the transition of these older children into homelessness, unemployment, and other problems, Massachusetts must work aggressively to implement needed programs now.

6. **Ensure school and educational continuity for foster children.**

Often, placements for teenagers are so difficult to find that schooling is rarely a consideration when making placement decisions. Frequent moves that result in different schools take away from most of these children the only anchor they have to consistency and social supports in their lives. Sadly, frequent moves also jeopardize their ability to keep up with schoolwork and to graduate on time or at all.

Chaffee guidelines and funds also address the educational needs of older children in foster care. Massachusetts must use these funds and explore pooling them with related grants administered by the Department of Education. Children in state custody are technically considered "homeless". Under federal law and protections children have the right to equal access to public schooling.

CHAPTER 11

Abused and Neglected Children and Adoption

There are 122,000 children in the United States currently waiting for permanent families.[212] The number of Massachusetts children in placement with a goal of adoption approached nearly 3,100 as of June 2000.

Children who are adopted have experienced loss. The impact of separation of a child from their biological family is a profound one, most often experienced by the child as trauma, regardless of the circumstances of that separation. For children in the DSS foster care system that move on to adoption, this reality can sometimes be underestimated by adults who experience the adoption only as a corrective and positive event. Because adoption can provoke in a child, mixed feelings and responses that can have lifelong implications, state systems must continue to upgrade their approaches to these special children.

RECOMMENDATIONS

1. **Actively include children in the process to plan for their adoption.**

   Children must be given information about what is happening to them and their family at every step of the adoption process. Information should be shared in ways that are appropriate to their age and developmental level. Including children actively in the adoption process will help alleviate the lack of control they often experience as a result of their family break-up.

2. **Implement "open adoption" practices.**

   Openness exists along a continuum and can be as passive as once-a-year anonymous letters or as active as face-to-face meetings and visits with biological parents and relatives. Such flexible practices recognize that each child is different and has varying needs that may need to be addressed differently.

3. **Consider concurrent planning when it is in the best interests of the child.**

Children who enter the child protective system must be assured permanency and stability as soon as possible. The child welfare system must examine various options for that child. If it is evident that a child's family might be unwilling or unable to have the child return to the family, then permanent placement options should be also be researched immediately.

4. **Consider kinship placements when appropriate, and provide supports to kin who care for children.**

Currently, kin families who raise children outside of DSS jurisdiction only receive financial assistance through "welfare" or TANF (Temporary Assistance for Needy Families) funds. These payments are substantially lower than approved foster care rates. Services available to foster and adoptive families are not necessarily available to kinship families. Equity in financial and other supports is recommended for relatives raising children.

Additionally, just consideration for waivers should be given to relative caregivers whose criminal background or "CORI" check may have turned up a previous violation. Regulations under the federal Adoption and Safe Families Act (ASFA) encourage these waivers when appropriate.

5. **Utilize Multidisciplinary Teams as consultants in the termination and permanency process, as well in the post-adoption period.**

Decisions about the dissolution of legal bonds between a child and parent and, too often, the separation of siblings that results, are the most profound decision made by those working in child protective services. Multidisciplinary teams should be called upon to review all cases in which legal termination is being considered.

Likewise, decisions about temporary removal of children from their homes and the conditions that would make return to home possible should be routinely reviewed by the teams. Individual caseworkers and supervisors should have the benefit of multidisciplinary input so that sound decisions can be made and the full burden of responsibility and risk can be shared. The use of teams in reviewing post-adoption problems would have similar benefits.

6. **Expand "permanency mediation" services.**

Mediation programs can work to resolve permanency issues in a more inclusive and timely manner and reduce adversarial dealings between biological parents and child welfare systems. When birth families have a role in their child's planning, it can help them make safe and appropriate decisions which result in better outcomes for children, reduced waiting time for children, and reduced costs to the system. Currently, Massachusetts has a successful statewide permanency mediation program that is funded through a state budgetary allocation. Every effort must be made to expand the successful elements of this approach, making it available to more families and in more circumstances.

7. **Ensure essential supports for adoptive parents and post-adoption treatment when indicated for their adopted children.**

Often, parents involved in adopting children from DSS are not fully aware of the child's previous history. Many of these children have experienced traumas that will have an impact on their lives far beyond removal from their traumatic environment - traumas that are bound to influence the child's functioning in the adoptive home.

The commitment to support adoptive families must include: accessibility to appropriate and competent mental health services and for the life of the child; continued advocacy, information and referral services after finalization; and a funding stream to ensure continuation of these services.

8. **Provide training for the broad range of professionals involved in termination of parental rights and adoption.**

The emotional impact of terminating parental rights and the process of adoption can be complex and difficult not only for biological and adoptive parents, but for the professionals involved in their cases. Ongoing adoption-competency education and training must be made available for judges, child welfare lawyers, school personnel, and other professionals who work with these families.

9. **Waive jurisdictional hearings for adoptive parents seeking therapeutic out-of-home placements through DSS for their adopted children with mental health problems.**

Children who have been in state care and are then adopted often face mental health crises, which require specialized placements at a hospital, in a therapeutic group home, or even back in foster care. Currently, families needing such placements for their children have two options for help: the Department of Mental Health (DMH) or the Department of Social Services.

While involvement with DMH has no implications for custody rights, children must meet the DMH eligibility requirements, and there must be an available spot in order for them to receive necessary services. Given the current shortage of in-patient and residential care services for minors, this is often impossible.

The alternative is to turn to DSS and seek placement through their system. Statutory regulations, however, currently require permanency hearings to determine under whose jurisdiction the child is being placed. Adoptive parents who seek voluntary services and supervision from DSS should not be subject to its permanency and custody procedures nor be obligated to attend a jurisdictional hearing. Legislation should be drafted so that a waiver can be issued sparing them from this process.

CHAPTER 12

Accountability in the Child Protection System

Citizen Review Panels

The Federal Child Abuse Prevention and Treatment Act (CAPTA) was amended in 1996 to direct the focus of its State grant program to support and improve child protective systems in the states.[213] The legislation authorizes an annual award of funds to states that submit plans every five years and meet certain eligibility requirements. One of the key requirements of the statute called for the establishment of Citizen Review Panels.

The purpose of these panels is to provide opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from abuse and neglect[214] Qualified citizens making up the panel would examine state policies and procedures and evaluate agency compliance with their State Plan on child protection.

Under this law, Massachusetts is required to create three Citizen Review Panels. Citizen Review Boards originated in the 1970s as a result of state-based initiatives to review the status of children in the foster care system. Efforts of successful review boards have resulted in increased community awareness and ownership of child abuse and neglect issues.

Professional Advisory Committee

Although the concept of citizen review of state child protective services is still relatively new, a citizen review panel has existed since 1984 in Massachusetts. That year, a voluntary Settlement Agreement was crafted following a lengthy lawsuit filed against the Department of Social Services by the Massachusetts Committee for

Children and Youth (now MCC). The suit was filed on behalf of abused and neglected children, and their right to be protected from harm while in the Department's custody. One provision in the Out-Of-Court Settlement Agreement called for an independent review board, or Professional Advisory Committee (PAC), made up of qualified citizens. The purpose of the committee was to provide DSS with independent and objective feedback on child protection issues and quality case practice so that systemic improvements could be made.

Over the past decade, the PAC role has been less than advisory. Until the current DSS Commissioner, Commissioner attendance at the PAC meetings had been infrequent. An annual report of recommendations to the Commissioner for improvements in practice and policy, an initial feature of the PAC, has also been dropped.

The PAC has been designated to serve as one of the three Citizen Review Boards required under the CAPTA legislation. It is intended that the PAC will continue to serve as a consultant to the Department during its internal investigation involving the deaths of children known to DSS. The other two newly formed Citizen Review Panels are structured in a similar manner to the PAC, but will primarily review case records as they relate to near fatalities. One will focus on the review of near fatality cases where substance abuse is a major dynamic within the family, the other on cases in which mental illness is the presenting problem.

Discussions with PAC members [215] suggest that the efficiency and usefulness of PAC and the other two Citizen Review Board could be significantly improved.

Child Death Review Teams

In July of 2000, legislation was enacted to establish a statewide system of child death review teams. The teams are designed to collect and review data on the causes of child deaths and to recommend policies and programs aimed at reducing preventable child deaths and injuries across the state. The experiences of other states indicate that such data can be successfully translated into legislation that can save children's lives.[216]

The law creates a state team and eleven local district teams. Local teams, chaired by the District Attorney of each county, will include designees from the Office of the Chief Medical Examiner, the Juvenile Division of the Trial Court, the Massachusetts Center for Sudden Infant Death Syndrome, the Department of Public Health, the Department of Social Services, a pediatric child abuse expert, as well as law enforcement representatives and others. District teams are charged with examining every child death in their county. It is anticipated that accidental and non-accidental deaths will be scrutinized in order to determine how they might have been prevented.

The Chief Medical Examiner will head the State Team. The State Team will include the Attorney General, the commissioner of several state agencies, including the Departments of Social Services, Public Health, Youth Services, Mental Health, Mental Retardation, and the Office of Child Care Services. Key law enforcement and pediatrician experts will also serve.

The State Team will develop protocols to address investigation and data collection by the district teams, and review the number and causes of child fatalities across the state. This data will serve to identify changes in policy and practice to reduce the incidence of child death and injury, including those resulting from child abuse and neglect. An annual report to the legislature and Governor will address these findings.

In conclusion, successful review boards can result in increased community awareness and ownership of child abuse and neglect issues. Understanding the strengths, weaknesses and challenges facing child protection systems, and translating that knowledge into meaningful policy are significant potential benefits of these panels. By developing effective boards, Massachusetts can ensure that these review bodies actually fulfill their intended mission of helping state agencies improve the lives of the children and families they serve.

RECOMMENDATIONS

1. **Expand the Role of the Professional Advisory Committee (PAC).**

   The original function of the PAC was to conduct reviews of randomly selected cases and to recommend to the Commissioner policy and practice improvements based on those reviews. The benefits of reviewing randomly selected cases in order to identify good practices that should be expanded or poor practices that should be improved, has been lost in recent years. The PAC's role has been narrowed to a review of cases in which children known to DSS have died from any cause, a function also served by the DSS Case Investigation Unit (CIU) that reviews the agency's performance in child death cases involving abuse or neglect.

   DSS should reinstitute the PAC's review of randomly selected cases. In addition, an annual written report to the Commissioner should be issued and made available to the legislature and the public.

2. **Reinstate the neutrality and independence of the PAC.**

   The locations of PAC meetings should be expanded to include other non-DSS Central Office sites. By holding meetings in various community sites, DSS can further promote the message that child abuse is best handled through state and community partnerships.

   The PAC should select a Chair from among its members. Recommendations from the PAC will be perceived as more credible if its leadership is seen as independent, i.e., not a DSS employee or DSS-contracting agency representative. Recommendations for meeting locations and election of leadership should be extended to the Citizen Review Panels, as well.

3. Provide professional quality assurance.

The sheer volume of data that is to be reviewed according to the federal guidelines suggests that the Department would benefit from contracting with quality assurance professionals who are able to apply professional methods of data gathering, examine aggregated data, and conduct quality assurance. Case practice review should be a core focus. In this regard, quality assurance professionals can also help establish protocols for review and assist the panels in their work. Case practice review, utilized in business and in the medical field, could be applied to child protective practice records, where complex data cannot be reviewed easily by individuals who meet only quarterly, and for only a few hours at a time.

4. Publish annual reports of the panels' work and recommendations.

The Citizen Review Boards must submit to the Commissioner of the Department annual reports that identify policy and practice areas requiring agency improvements. These reports should be made available to the legislature and the public. The Commissioner must work actively with the Boards to act on these areas of suggested policy and practice improvement.

5. Establish oversight by the Executive Office of Health and Human Services.

An examination of the various review functions among the PAC, the recently established Citizen Review Boards, and the legislatively mandated Child Death Review Teams would uncover redundancies in the functions of these boards, and identify gaps in the review process. Both the PAC and the Child Death Review Teams are charged with reviewing child deaths in Massachusetts, though the PAC currently focuses more narrowly on the Department's role in the case. Near-deaths of children in child abuse and domestic violence cases might be overlooked unless these cases involve substance abuse or mental illness. Also, cases that are serious, but do not reach the threshold of "near-death", may not be included at all in the current scope of review by any of the review bodies.

Oversight and coordination of these review teams by the Executive Office of Health and Human Services could help identify ways to avoid redundancies, address gaps, and ensure uniform protocols for efficiency and quality assurance.

CHAPTER 13

Abused/Neglected Children and the Courts

There are currently several courts in Massachusetts that handle cases involving children. **Probate Courts** oversee issues of custody and visitation in the context of divorce and custody proceedings. **Juvenile Courts** handle a wide spectrum of cases, including child abuse and neglect (Care and Protection), adoption, delinquency and status offense cases. **District Courts** are the sites for restraining orders or "209 A" requests in domestic violence cases that often involve emergency situations with children and protective parents. **Criminal Courts** are the sites for prosecution of child abuse perpetrators. In these proceedings, child victims are required to testify as witnesses against their abusers.

Information Sharing Among Courts

Often, a single complex case can be heard by more than one judge. For example, a divorce case involving a child custody matter might also concurrently involve a Care and Protection, delinquency or CHINS (Children in Need of Services) case. If a parent and children seek a restraining order against another family member, they would need to file a restraining order in District Court even though the family may be involved in Juvenile Court.

Several jurisdictions have adopted unified family courts that enable one court to hear many different issues as they relate to specific families and children. This provides for children a mechanism to facilitate coordination in proceedings that involve them. For example, restraining orders blocking visitation in one court must be shared with the court hearing custody and visitation matters relating to that child.

In Massachusetts, there is a mechanism currently in place intended to do this, e.g. when a District Court issues an emergency restraining order and the family is already involved in a Probate Court matter. However, given the number of Courts in Massachusetts that hear cases involving children, the state still requires a system to better coordinate information in these often-complex cases.

Reporting of Child Abuse Allegations by the Courts

There are gaps in coordination and information sharing among the different courts, and among the courts, DSS, and the District Attorney's Offices. For example, there is little coordination among Probate Courts to refer matters of serious abuse directly to the investigative authorities. Child welfare practitioners report that allegations of physical or sexual abuse made against parent abusers during Probate hearings are not given the same credence as allegations of abuse between a stranger and a child.

Although Probate courts do refer cases to private evaluators for evaluation and forensic interviewing the skills of these evaluators may differ in significant ways from the forensic interviewing offered by the county's Sexual Abuse Investigative Network (SAIN Team) or Children's Advocacy Center. As described below, there is no significant oversight of these evaluators and there is no mandated training. Far too often in Probate proceedings, Courts dismiss allegations of abuse without even the benefit of interviewing the child.

Because of reporting problems, an allegation of sexual abuse made in Probate Court may never be reviewed by the District Attorney's Office for possible prosecution or by DSS to evaluate the validity of the allegations. Under Massachusetts' child abuse reporting law, clerks or clerk magistrates in the Probate Court are not required to report. Although clerks or clerk magistrates of the District Courts are mandated reporters, they often do not make reports as required. Furthermore, confusion exists about which Court personnel are obligated to report. For example, "Family Service Officers" in Probate Court are not specifically mentioned in the statute, but since they fall officially under the category of "probation officer," they are required to report suspected cases.

There must be an effective response mechanism among all Courts working with children to ensure referrals to appropriate investigative or clinical services. Other states have created protocols and procedures to ensure uniform, non-discretionary referrals among court personnel. In these jurisdictions, if an allegation of abuse surfaces in a family law matter, judges are mandated to refer the matter to the state child protection agency, law enforcement, or delegate that function to the Clerk of the Court. (In Massachusetts, judges are *not* mandated reporters.)

The Massachusetts Court needs to reassert how suspected victims of child abuse that come to its attention other than through Juvenile Court will be appropriately referred for assessment and services. *It is untenable that children who find themselves before such Courts could present as possible victims of abuse or neglect and not trigger the Court's protective response.*

Guardians Ad Litem

In cases involving children, judges can appoint a Guardian Ad Litem (GAL), usually an attorney or clinician. One of the roles that GALs play in our current system is to serve as a neutral reporter on the facts of the case as they relate to the child's best interests. Until recently, GALs have often been appointed based on the judge's familiarity with an individual GAL. This selection process resulted in protests from GALs who were less frequently chosen. Selection can also be made by mutual agreement of the parties to the case, but, again, not pursuant to any standardized criteria.

The current Trial Court policy regarding "Fee Generating Appointments" now applies to all Courts and sharply limits the discretion of a judge in terms of who can be appointed to specific cases. Since appointments are to be made sequentially from a list, the capacity to match GAL evaluators with certain types of expertise to related cases has been lost. Both the former and current methods of selecting GALs contain inherent shortcomings.

Despite the lack of formal mandatory training, GALs advise the Court on recommendations relating to child placement, whether or not abuse occurred, and whether or not a child victim should have contact with his or her parent abuser. This is in stark contrast with the mandatory training for Court Investigators who do fact-finding investigations on behalf of the Juvenile Court in Care and Protection proceedings.

GALs in Probate Court may be appointed and paid through State funding at a rate of approximately $40 per hour if parties are unable to pay. Sometimes when these GALs are not compensated through the state, the cost is split by some formula between the parents, depending usually upon income and resources - including having only one parent pay the entire GAL cost. Typically, they will charge from $90 to $150 per hour. An evaluation to determine visitation or contact between the child and the offending parent can cost thousands of dollars. In contrast, Juvenile Court GALs are virtually always paid through state funding and parties are not assessed costs.

While some GALs have developed well-deserved reputations as wise and thoughtful advisors, others are prepared poorly for the task. Some are conscientious about meeting with the child and other related parties several times prior to issuing their recommendations to the court, while others never talk to or see the child prior to their court date.

Anecdotal information uncovered by MCC as a result of preparing this report points to the fact that personal ideologies can sometimes clash with the best interests of children. For example, one Massachusetts GAL has stated publicly in court that he does not believe in child sexual abuse. Clearly, recommendations on sexual abuse matters by such an individual could influence court decisions that may result in further revictimization of a child. In contrast, some GALs may be biased in presuming that every allegation of sexual abuse is likely to be true. In each instance, poorly trained GALS, or GALs with rigid personal ideologies can have damaging impact on children's lives no matter which way the error goes.

A 1989 study by the Massachusetts Supreme Judicial Court found that in cases involving custody and visitation litigation, "the interests of fathers are given more weight than the interests of mothers and children."[217] This gender bias persists in cases involving a history of spouse abuse but also in those involving children who have been victims of physical or sexual abuse. Mothers who are seeking to protect their children from further trauma may not be supported in their attempts to prevent visitations and phone or mail contact.

Some GALs may ignore sound recommendations from clinicians with experience in childhood trauma and a history of extensive contacts with the child. Other GALs appear motivated ideologically to uphold parental rights of abusers over children's rights. Still others appear influenced by strong pressure from parent abusers to recommend rulings in their favor. Though GALs have quasi-judicial immunity and cannot be sued, license complaints may be filed with the professional associations to which the GAL may belong, e.g. the American Psychological Association. It is unclear what action, if any, results from these filings.

There is currently no formal accountability or oversight of GALs in Massachusetts. A trade organization does exist - the Massachusetts Guardian Ad Litem Association - and beginning this year it will require its members to complete two days per year of training. Membership in the association, however, is voluntary. No formal State accreditation or licensing of GALs is required in Massachusetts and there is currently no body authorized to provide standards of quality, experience or accountability.

The Women's Right Network, a human rights organization based at the Wellesley Centers for Women, has recently launched a project to address custody and visitation problems faced by battered women and their children in the Massachusetts family court system. This new study, the "Battered Mothers' Testimony Project: A Human Right Report on Child Custody & Domestic Violence in Massachusetts," intends to document harmful actions by state agents of the courts. It will address the issue of awarding unsupervised visitation to perpetrators despite evidence of child physical or sexual abuse. Also to be documented is refusal of state agents of the court to investigate or respond to allegations that custody evaluators or GALs have lied in their reports, distorted facts, or have in other ways shown gross bias or negligence.[218]

In addition, the Senate Committee on Post Audit and Oversight has also been documenting problems within the GAL system. MCC supports the work of the Women's Rights Network and the Senate Committee to formally document problems in the GAL system and urges collaboration between these efforts in order to implement recommended policy changes.

Assessment Teams and the Courts

As indicated in the Chapter 8 under "Multidisciplinary Teams and the Courts," the quality of judges' decisions in complex matters involving children and families is dependent on the quality of information received. Teams can provide the courts with invaluable information about the child - information that can often be left out due to overburdened social workers, poorly trained GALs, or inexperienced or incompetent counsel for the child.

If a child is sexually or physically assaulted by a stranger, prosecution would be handled in District or Superior Court, depending on the severity of the abuse. The District Attorney's Office would work with the child victim to assess their availability to testify and assist in the prosecution of the offender. When the abuser is a parent and has access to the child, however, the procedure for handling cases of abuse can become considerably more complicated.

Under current practice, the Department of Social Services "screens-in" or formally accepts cases of serious physical or sexual abuse when they involve a parent or caretaker as the offender. If, after an investigation, DSS "supports" the finding of sexual abuse, it refers the matter to the District Attorney's Office for prosecution. Often the decision of whether or not to prosecute is made jointly between DSS and the District Attorney after the child has been interviewed.

If a child has been abused but is residing with the non-abusing parent or caretaker, DSS can and often does choose to screen out the case – in other words, not to assume any jurisdiction over the matter. In such cases, the Probate Court handles issues such as parent/victim contact. This places the burden on the protective parent to request termination of visitation, or of supervised visitation by the offending parent. If that parent cannot afford litigation costs, or is deterred from making the request due to fear of domestic violence or other reasons, the child by default may not be protected against the abusing parent.

While it may be impractical or even unwarranted for DSS to remain involved in all cases where a protective parent is fully capable of keeping a child safe, children could still benefit from referral to a specialized team.

Court referrals to multidisciplinary teams could serve several functions:

> *Evaluation and Treatment*
>
> Cases of abuse, particularly sexual abuse, are often suspected as a result of a child's behavior. Even without a formal disclosure, these behaviors can lead professionals, parents, and courts to raise concern about a child's safety or mental health. A multidisciplinary team specializing in assessment and treatment of abuse could evaluate these behaviors and either rule out or help confirm the abuse. Recommendations relating to appropriate follow-up treatment for child victims could be made, thus assuring appropriate clinical intervention and/or prosecution when indicated.
>
> *Coordination of Civil and Criminal Matters*
>
> The Probate Court is concerned with issues pertaining to visitation and custody matters, and not to the prosecution of child abuse. Coordination is necessary between civil and criminal courts so that allegations of child abuse are not treated merely as a "family matter" when they surface in Probate Court. Sexual abuse is a serious criminal act that could result in prosecution of a family member. Multidisciplinary teams could serve as a liaison between the Probate Court and the District Attorney's Offices. This would ensure that cases of sexual abuse uncovered in Probate proceedings trigger the same

level of investigation as those referred to the District Attorney's Offices as a result of "stranger" abuse cases.

Recommendations Relating to Parent/Victim Contact

Arbitrary or ill-conceived recommendations to the courts relating to perpetrator/victim contact, could be reduced or eliminated if recommendations to the courts were made by multidisciplinary child protection teams comprised of clinicians, representatives from the District Attorney's Office, the Department of Social Services, and other child welfare professionals. GALs could participate on these teams on a case specific basis and assist in the evaluation and assessment. Recommendations about parent/victim contact could then be made by the team. DSS' role could be to provide oversight in such cases, and arrange for supervision that would ensure the child's safety, if contact with the offending parent was indicated by the team and supported by the Court.

Safety Planning for Children

Currently, our present system does not allow the Courts to impose safety planning for children when abuse has not been proven by a preponderance of the evidence. In civil court proceedings, these children would no longer be deemed at risk of abuse. In many situations, however, children may still face significant danger, even though they may be unable or unwilling to disclose.

This "all or nothing" standard can compromise child safety and mental health. Courts - especially Probate Courts – can, and in specific cases, should impose supervised visitations or other "safety planning" elements, even in the absence of a legal finding of abuse. The Court, for example, supported by evaluation findings of a multidisciplinary team, could raise serious concerns about a child exhibiting trauma-related behavior in direct response to the presence of an alleged perpetrator. The Court, in such a case, need not find that the child has been abused by a preponderance of the evidence before limiting visitation or imposing supervised visitation.

Court-Friendly Practices For Child Victim Witnesses

The Supreme Judicial Court has ruled that courtroom modifications for children violate the Massachusetts Constitution, which in criminal cases provides for a defendant's right to confront his accusers. Current practices regarding the testimony of child witnesses should be reviewed, however, to determine whether legislation is required to address discretion of the judiciary to adapt courtrooms to accommodate the needs of child witnesses, for example, allowing a trusted caregiver to remain in the courtroom, or frequent breaks for children who, as a class, have special needs.

Massachusetts does have laws that in special circumstances allow a child to refrain from testimony under certain stringent guidelines. The child must be unavailable, or unable to testify due to severe emotional vulnerability. Although not all children, especially older children and teens, are "anguished" by offering testimony - some actually find it empowering and vindicating - it is difficult to apply so strict a standard to younger child witnesses. Some jurisdictions have legislated special protections for child witnesses, allowing for examination and cross-examination of the child by close-circuit televisions, or in special examination rooms. This spares the child the anxiety of facing his or her abuser who is often a parent or relative. *We must find creative ways, even within the confines of the Massachusetts Constitution, to ensure that our Courts are responsive to the special needs of child victims.*

Judicial Training in Child Protection

Judges are hearing cases of abuse, neglect and emotional harm that involve complex dynamics. Although under our proposed recommendations judges in these cases should be guided by the advice of skilled multidisciplinary teams, they also need to have a fundamental understanding of child abuse and its traumatic effects on child development and functioning. Essential elements of the training curricula in child protection for judges should include: an understanding of the medical aspects of child abuse, the dynamics of abuse disclosure, a child victim's need for confidentiality, forensic interviewing techniques, and the latest findings in the field.

Although many elements of this judicial training are currently offered, training is not mandatory. Professionals who routinely offer these trainings have reported that many judges who could benefit do not attend. Judicial training in these areas should be mandatory.

Jeremy and Isaac

It is important to note that for one group of children - those in the formal custody of the Department of Social Services - the courts may have a limited child protection role. In 1995, two significant child welfare cases, Care and Protection of Isaac,[219] and Care and Protection of Jeremy,[220] were argued before the Massachusetts Supreme Judicial Court (SJC). In both of these cases, the SJC was asked to decide whether a judge could order a specific type of placement for a child over the objections of the Department of Social Services. The SJC ruling that followed has significantly altered the working relationships among the Court, DSS, and parties to cases involving children in the custody of the Department.

In each of these cases, the Department's proposed placement of the child was challenged. For example, in Jeremy, the minor had resided in a series of foster homes until he was removed from each of these homes due to aggressive and disruptive behavior. The Department requested the Juvenile Court judge's permission to place the minor in a long-term residential treatment program. The child's attorney objected and requested that Jeremy be placed in the less restrictive setting of a specialized foster home. Over the next few months, Jeremy resided in two short-term facilities. Finally, the judge entered an order requiring the Department to place Jeremy in a specialized foster home. The Department attempted to comply with this order without success, and appealed.

On appeal, the SJC ruled that the Juvenile Court is prohibited from making decisions relating to placement of a minor if that child is in DSS custody. As a result of this ruling, the Department is the sole determiner of the best interests of children within its custody and it may use cost and availability of placements when considering its options. Because of the current shortage of specialized placement services, the Department cannot always provide children in its custody with an adequate placement.

The Juvenile Court's review of the placement is now confined to whether the Department has committed an error of law, or abused its discretion. This means that the party contesting either the placement of the child or the services provided to that child has the burden of proving that the Department has abused its discretion. Examples of this abuse of discretion could involve a DSS decision that interferes unduly with the goal of reuniting a child with his biological parents, or that does not properly consider maintaining connections among siblings and other family members. Choosing one type of treatment or therapeutic placement over another may not necessarily qualify as an abuse of discretion, even if qualified experts conclude that a better service plan for a child exists.

An MCC survey of state and national experts in the field of child protection documented support for the legislature to address the issues raised in Isaac and Jeremy. These experts believe that all parties in a child protection case should have the right to provide the court with expert testimony, so that the court can make decisions that reflect the best interests of the child. They believe the court should have the discretion to order certain services and placements based on the testimony of expert witnesses.

RECOMMENDATIONS

1. **Develop protocols for information sharing among courts.**

   The often complex nature of cases involving children and the number of Courts in Massachusetts that hear children's cases, requires that the State establish protocols to better share and coordinate information in these cases.

2. **Ensure reporting by the Courts of all cases involving child abuse allegations or suspected abuse or neglect.**

   Victims of child abuse and neglect frequently present to the Courts during proceedings other than in Juvenile Court. All court-related personnel mandated by Massachusetts' law must be trained to report suspected cases or cases in which allegations of abuse have been made, in order to ensure uniform, non-discretionary referrals and trigger appropriate protective responses and services.

3. **Establish accountability in the Guardian Ad Litem Program.**

   The State must document current weaknesses in the GAL system and establish accountability in the program. At a minimum, standards of competency and experience should be addressed, as well as pre-training requirements and pre-certification to screen out inappropriate or unqualified GAL applicants. Ongoing mandatory training should be in place to ensure that GALs are aware of the latest knowledge and best practices in the field. A registry of licensed GALs should be maintained so that the courts and the public have an opportunity to notify the registry when GALs have performed in an exemplary or incompetent fashion.

4. **Make consultations from Multidisciplinary Child Protection Teams available to the Courts in cases of suspected or confirmed cases of child abuse and neglect.**

   Decision-making by the Courts in matters involving children could be improved through linkages between the Courts and multidisciplinary teams. Proposed court-related functions of the teams include: evaluations to help confirm or rule out suspected abuse; coordination of civil and criminal matters through liaison between the Probate Court and the District Attorney's Office; recommendations relating to perpetrator/victim contact; and consultation regarding safety planning for suspected or confirmed child victims.

5. **Establish court-friendly practices for child victim witnesses.**

   Even if current Massachusetts case law bars modifications for child testimony, the practices regarding the preparation of child witnesses, transportation, waiting in court, and supportive persons in court might be feasible and beneficial to child victims of abuse.

6. **Mandate judicial training in child protection.**

   Judges who routinely deal with issues of child protection should be required to participate in training around these complex issues. This would ensure that decisions are informed by the latest knowledge relating to clinical and protective practice.

7. **Provide legislative review of the cases of Jeremy and Isaac.**

   The Courts have a compelling interest in ensuring permanency for children at the earliest possible date, and in ensuring that the therapeutic needs of traumatized child are addressed. As the Supreme Judicial Court has suggested, the legislature must examine the cases of Jeremy and Isaac in order to define more clearly the scope of the Court's authority when making decisions about placement of children in the custody of the Department of Social Services.

SECTION IV

Healing Our Children

The children of the Commonwealth of Massachusetts are our gift, our inheritance, our awesome responsibility. They are bright and beautiful and full of potential…As adults, we must do everything we can to secure their future.

Reverend Ray Hammond, Pastor, Bethel AME Church
Invocation at the Summit on Child Protection and
Family Support, May 1999

CHAPTER 14

Treatment and Intervention: The Essentials to Healing

As described earlier, the experience of witnessing violence or the trauma of having been neglected or physically, sexually or verbally abused in childhood have been linked to a variety of serious and enduring problems for a vast number of its victims. Depression, anxiety, psychiatric disorders, delinquent behavior, substance abuse, spousal abuse, and violence are all too common.

As a West African proverb states, "Rain does not fall on one roof alone." The effects of child abuse are not felt only by its victims, but in so many tangible ways, by all members of the community. Any effort that hopes to succeed in ending child maltreatment must be committed to ensuring that children receive the full complement of therapeutic services they require to recover as fully as possible from the effects of their abuse or neglect. The challenge to the State, the legislature and the public-at-large is how to ensure these children the services they need and deserve - in other words, how to help them heal.

The Mental Health Care Crisis in Massachusetts

Research shows that the effectiveness of treatment is optimized when provided soon after the traumatic occurrences. Great strides have been made in understanding which interventions work best to maximize the recovery of children who have experienced or witnessed violence or have suffered from neglect. This new information must be incorporated into clinical and protective practices, as well as into public policies that affect children. These are difficult to address, however, until we successfully confront the escalating problems in our state's mental health system.

Few would challenge the assertion that the mental health care system in Massachusetts is in dire crisis. A study conducted by the Children's League of

Massachusetts in 2000[221] documents a critical shortage of services for children who require mental health care. Though many of these children suffer from organic mental illnesses and have loving and devoted families, the population of children that requires mental health care also includes the victims of serious abuse and neglect.

Residential and Outpatient Care

Recent reports have heightened the public's awareness of the plight of children trapped in psychiatric wards or mental health units where they become more despairing as they wait for appropriate referrals to therapeutic homes. Others who need specialized in-patient level care are turned away from child psychiatric wards due to a shortage of beds.

The need is so acute that children often wait long periods of time in Emergency Rooms waiting for a bed to become available. The lack of timely and appropriate residential services can compound these children's already fragile coping abilities. For example, in one publicized case, a traumatized child whose family was seeking placement for him was sent home from an Emergency Room only to cut himself with a knife and then beat his 3-year old brother.[222]

The Children's League study also concluded that youth participating in residential treatment programs have grown more difficult to serve. They report an increase in the severity of emotional and behavioral issues they face. **Children are presenting more serious levels of pathology, their numbers are increasing, and their hopes for treatment and recovery are diminishing due to the shortage of beds and the lack of qualified treatment providers in our state.**

The private sector is not the only group to report these critical shortages. The Department of Mental Health reported in 2000 that 2,500 children were on waiting lists for services.

Hospitals have also reduced social services and treatment in response to reduced funding. Parents on the North Shore, Fall River and other communities report waiting lists of up to five months for outpatient treatment services.[223] Other outpatient child psychiatric services at the major medical centers in Boston that offer new treatments for trauma-surviving children are operating at a loss to the parent institution, and many have been, or are being, reduced or eliminated.

Other services within non-profit provider organizations are also operating at a loss and are subsidized by endowments or income from other revenue generating programs. These funds can only serve as temporary sources of support.

Evaluations

Massachusetts also faces a critical shortage of evaluation options for children who present as *possible* victims of sexual abuse. Currently in our state, children who engage in sexually inappropriate behaviors that suggest prior abuse, or children who have disclosed their abuse - but to another child - cannot receive appropriate treatment without a comprehensive sexual abuse evaluation. Unfortunately, the heightened cost of these evaluations has become a major obstacle for institutions like New England Medical Center, Boston Medical Center, and others, in documenting and treating child sexual abuse.

For many children, this lack of evaluation resources threatens to turn the silent tragedy of child sexual abuse into an invisible one. One example, involves Children's Hospital of Boston and the Sexual Abuse Treatment Team (SATT) operating within its Department of Psychiatry. Although the hospital has received national acclaim for its work in evaluating children identified as potential victims of sexual abuse, recently the services normally provided to these children have been too costly to maintain.

In 2000, the SATT team was dissolved as a cost saving measure. The disincentive to continue operating was understandable - the more evaluations they performed, the greater the financial loss to the hospital. Although, the Child Protection Team still functions at Children's Hospital and has absorbed some of the SATT functions, there is still a large deficit in available evaluation and treatment services for these child victims.

Specialized treatment options for children whose sexual abuse has been confirmed is also sorely lacking. Research shows that the best treatment for these trauma victims is abuse-specific treatment, yet **there are too few experienced clinicians with knowledge of trauma and sexual abuse in Massachusetts**. Inadequate reimbursements by managed care systems have been a major predicament for clinicians and institutions currently providing these services and a major disincentive to attracting others into this field of practice.

Given the long-term benefits and cost savings of quality care for these children, reimbursements that cover actual costs must be provided to hospitals and practitioners with expertise in child abuse evaluation and treatment. These reimbursements must include support for collateral contacts with family members, teachers, and other service providers.

Many maintain that current mental health services for victims of abuse and neglect are organized in ways that frequently undermine recovery and at times even re-traumatize children. Reimbursement structures have pushed private providers into "fee-for service" arrangements that have resulted in part-time, temporary working patterns and high clinical staff turnovers. This places an unfair burden on already vulnerable children who very much need to develop a consistent and ongoing therapeutic relationship.

Innovations in Trauma Treatment

Although some traumatized children continue to benefit from traditional therapy and abuse-specific treatment, research is showing that some new treatment approaches can be far more effective for many traumatized children.

Multisystemic Therapy (MST)

One effective treatment strategy for traumatized children is the "social-ecological" model, or the "Multisystemic" Therapy (MST) approach. This therapeutic model is based on an understanding of the child as inextricably linked to family, community, and school. It argues that in order to meet the mental health needs of traumatized children, careful attention must be paid to the child's environment and the "social-ecology" which has broken down in many different ways.[224]

Children who have been abused often display a broad range of emotions and behaviors including, fear, aggression and dissociation. A core theme of the MST approach is that trauma from the abuse or neglect causes a "dysregulated" nervous system and an accompanying family and social environment that cannot contain the dysregulation.

An initial goal of treatment is to create calm and stability and to help build cognitive structures in the traumatized child that help him place discriminating thought between a stimulus and his response to it. This is accomplished by helping a child first become aware of his feelings, then label his feelings and finally, develop strategies that regulate feelings once they are labeled. By developing these cognitive supports, children come to learn that they have new, more positive choices in their behavior.

When examining the child's environment under this model, questions are raised about the child's safety and basic needs, to what degree the overall environment is stressful, and whether the child is in the right educational setting.[225] Therapeutic contacts with the child and his or her family emphasize the positive, and use strengths in the child's environment as levers for change.

Interventions target specific and well-defined issues. Everyone involved becomes aware of the specific problems and their roles in perpetuating or solving them. An understanding develops about the sequences of behavior among the various systems in the child's life, e.g. how an intrusive symptom of the trauma can impact on school issues that can then influence a specific family response to the child. The interventions eventually promote responsible and therapeutically appropriate behavior and decrease irresponsible behaviors in all these settings.

MST, currently being used with violent and aggressive children, traumatized children, homicidal and substance abusing children, has the following core components:[226]

- Low caseload - 3 to 5 families per full time therapist
- Services provided in the child's own environment
- Time limited duration of treatment, 3-5 months per family
- Therapist functioning within a team of 3-4 clinicians
- Appointments at families conveniences, such as evening hours and weekends
- Daily contact with family - face to face or by phone

Outcome Data

Data from outcome studies are encouraging. In one study involving 200 chronic juvenile offenders, youth who received MST showed:

- A decreased rate of 22 percent recidivism versus 71 percent in the control group.
- Fewer violence- or drug-related arrests and significantly greater improvements in family cohesion.[227]

In a randomized trial of MST versus clinic-based parent training among DSS families with abuse and neglect histories, results showed:

- Significantly greater improvements in the MST parent group including, more effective parental behavior management and more appropriate parental responses to children, suggesting a reduced risk of maltreatment.[228]

In another study of severely traumatized children, 113 children and adolescents were approved for emergency psychiatric hospitalization. Youth entering the study met the criteria for severe emotional disturbance, and utilized multiple service agencies, including mental health, juvenile justice and social services. A randomized trial of MST versus inpatient hospitalization and "treatment as usual" was conducted. The results were stunning.

- The MST population had greater improvements and exhibited fewer symptoms;
- Family structure and cohesion was improved;
- School attendance improved;
- No additional hospitalization was warranted for 57 percent of the MST group. Overall days of hospitalization in the MST group were reduced by 72 percent, and days in other out-of-home placements were reduced by 49 percent.[229]

It has been estimated that one team of 3 MST therapists can effectively treat 50 families a year at a cost of $5,000 per family. The annual cost of an entire program is about $250,000.[230] When considering the short-term saving of preventing out-of-home placements, residential care, psychiatric hospitalizations, as well as the long-term savings of preventing imprisonment, substance abuse and chronic medical and mental illness – **MST is an approach that can document significant success and savings.**

Trauma and Movement Therapies

Psychodrama and other social group rituals involving movement and imagination are some of the oldest ways in which individuals and communities have historically dealt with trauma. These approaches are now being used as formal interventions to assist traumatized children.

As we have seen, children who are victimized by trauma are often unable to develop or experience mastery and sense of self, or to separate themselves psychologically from the violent physical experiences that produced their trauma. New research suggests that the neurobiological effects of trauma are as real as their emotional consequences. The body appears to "keep score" of traumatic memories and is a theatre where the memory of trauma is often reenacted.

Research by van der Kolk and others has major implications for the role that physical education, sports, and art can play in healing and promoting self-confidence and mastery. By creating what van der Kolk refers to as "islands of competence", traumatized children can develop new coping strategies and behavioral skills that can promote healing, something, he argues, that may not be achieved through traditional talking therapies alone.

RECOMMENDATIONS

1. **Establish an entitlement to effective treatment for abused, neglected and traumatized children in Massachusetts.**

   The significant effects of abuse and neglect on children's physical, emotional, educational and social well-being, and their costly social and fiscal impact on our communities and state demand that we secure a formal entitlement to quality care and treatment for these children. An unprecedented state-level commitment must be made to entitle every child victim of abuse, neglect or trauma in Massachusetts to the full complement of therapeutic and other services and supports needed to recover as fully as possible from the effects of their maltreatment.

2. **Establish waivers within the current Mental Health Managed Care system to respond fairly to the special needs of children diagnosed with child abuse, neglect or trauma.**

   A separate category for trauma-recovering children, outside the current behavioral managed health care capitation system, should be implemented immediately in Massachusetts. Current models of treatment under managed care systems often assume that children need only short-term, infrequent and intermittent care. This is not the case for many victims of abuse, neglect and trauma. A diagnosis of abuse, neglect or trauma based on a formal evaluation of the child should trigger a waiver from limitations in the type, duration and frequency of clinical services provided for this special population. The management of these children's care and the specific services they require should be determined by competent clinicians and multidisciplinary assessment teams, and not by managed care agents.

3. **Expand the range of interventions for abused, neglected and traumatized children and provide adequate reimbursement for evaluations and case coordination activities related to these interventions.**

   There must be an expansion and support for evaluations of children who present with possible sexual abuse; specialized treatment for child victims and child perpetrators of sexual abuse; therapeutic group homes; and ecological models of treatment, including Multisystemic Therapy, that address the unique needs of the traumatized child within the context of family and community.

   Reimbursements must be available for coordination and collaboration activities between the service provider or clinician and other collateral professionals involved with these children. Failure to reimburse for these essential activities has undermined the provision of quality care.

4. **Pilot, evaluate, and implement effective treatment and interventions based on new research and findings on brain development and childhood trauma.**

   Massachusetts is fortunate in that it is home to several key researchers and institutions working to translate new brain research findings into more effective interventions for abused, neglected, and traumatized children. The State would do well to develop ongoing collaborations with these experts, including the funding of pilot studies, so that proven approaches can be incorporated within the state's child welfare and mental health systems of care.

5. **Establish a Board of Education-sponsored scholarship and payback program for graduates in social service and mental health fields.**

   Service providers in mental health and social services report a significant drop in the numbers of trained and qualified workers over the past decade. Limitations in client coverage and reimbursements, non-competitive salaries, and the high-cost of living in our state have all contributed to this shortage of specialized workers. One proposal to address this trend is through a Board of Higher Education-sponsored college scholarship program, complete with service payback provisions for graduates willing to enter these fields.

6. **Create "blended" funding pools within state agencies serving children to maximize services, and support inter-Departmental coordination and collaboration to encourage flexible and creative use of resources.**

   Blended funding from a variety of state agency resources must be pooled to ensure that children and families receive the services they need. In order to promote the flexible and creative use of state dollars, collaboration among agencies must be coordinated centrally through a statewide mandate, backed with sufficient resources and quality assurance. The needs of the child and family should be the central driving force behind collaboration and information sharing among state agencies and providers.

CHAPTER 15

The Role of Schools in the Life of the Traumatized Child

It is no surprise that children struggling with the effects of traumatic exposure to family violence, either as witnesses or through direct abuse, often have difficulty focusing, following rules, trusting adults and peers, and completing academic tasks.[231] For some children, this difficulty can result in a failure to succeed, which can, in turn, lead to dropping out of school or engaging in disruptive behavior. For other children, the outward signs of trauma can be less disruptive to the classroom, but nevertheless devastating to a child's school experience. Such symptoms include perfectionism, depression, anxiety, and self-destructive or even suicidal behavior.[232]

The following summary from the Massachusetts Advocacy Center describes the case of Sam and exemplifies how abuse-related problems can become compounded when our systems of care respond poorly or not at all.

> *Sam was removed from a pre-adoptive home where he had been physically abused. Returned to foster care at the age of 12, no one in the system diagnosed his trauma symptoms. His DSS social worker took him to a mental health center, but there were no placements for a child who was suffering from so much disappointment and hurt. At school, he began fighting with other children and was expelled for hurting a teacher who tried to break up a fight.*
>
> *He subsequently moved through 15 foster homes with no schooling until finally, at the age of 14, he was referred to the Massachusetts Advocacy Center for legal representation. Finally, two years after the abuse, he was diagnosed with posttraumatic stress syndrome and placed in a school for children with behavior problems. He continues to struggle to overcome his anger to this day.*

Though the task is complex, schools have an enormous opportunity to assist children exposed to violence. Schools can function as a non-chaotic and non-stigmatizing "community" where children can learn how to trust adults and function appropriately.[233] The small schools movement which encourages smaller schools, smaller classrooms, mentoring, and environments where adults know each child, will be very beneficial to this group of students. However, it is critical that trauma specific approaches be developed now for all schools so that the needs of children traumatized from exposure to violent environments can be addressed.

It must be emphasized that schools cannot undertake this job alone. Community resources including mental health centers, social service agencies, community centers, and housing agencies must collaborate with school personnel at the most basic levels to support teacher efforts to foster the success of traumatized children in the non-stigmatizing environment of the public school. Through consistent support and encouragement, teachers can be regular lifelines to children who come to believe they are helpless, behave helplessly and are often punished, disregarded, or disrespected for their seeming lack of motivation. This will require a concerted system of support within schools and from outside of schools.

RECOMMENDATIONS

The following are recommendations from the ***Task Force on Children Affected by Domestic Violence*** coordinated by the Massachusetts Advocacy Center (MAC), and supplemented by participants at the spring, 2000 Symposia convened by MCC on "The Impact of Trauma on Children: Implications for Policy, Protection and Prevention." Comments from participants at "Helping Traumatized Children Learn," a subsequent conference sponsored by MAC and Lesley University Center for Special Education, are also included.

1. **Stop the re-traumatization of children in schools.**

   Training educators to identify the symptoms of traumatized children is a crucial starting point in developing a comprehensive school-wide approach to helping traumatized children learn. At a minimum, a training curriculum should:

   Help teachers understand that traumatized children may not be able to express their suffering in ways adults can understand:

   Lacking the words to communicate their pain, these children may express feelings of vulnerability by "acting out," becoming aggressive, or feigning disinterest in academic success because they believe they can't succeed.[234] Teachers must be helped to understand that the traumatic symptoms most detrimental to children's educational experiences often do not originate in willful defiance, but in their feelings of vulnerability. With this insight, school personnel are far less likely to re-traumatize children with surface-oriented punishments, such as suspension and expulsion, "dumbed-down curriculums," and demeaning comments ("You're not trying.")[235]

Emphasize the negative effects of publicly labeling specific children as "traumatized" or "abused."

This is critical to ensure that the experiences of maltreatment do not become the prominent feature of any child's identity.

Emphasize the importance of helping children feel safe:

Many traumatized children engage in disruptive behavior and/or are unable to concentrate on academic tasks because they are afraid. In order to educate these children, it is necessary to help them feel both physically and emotionally safe within the school setting. Only when they feel safe, (including safe from teasing and bullying) can they begin to learn to modulate their emotions, enabling them to focus on the important academic tasks before them.[236]

Teach children how to calm themselves and modulate their emotions;

When children bring traumatic memories with them to school, any event (a look, the color of your hair) that reminds them of their trauma can trigger behaviors that may not be appropriate in the classroom. (This is a classic symptom of Posttraumatic Stress Disorder discussed earlier.) Mental health professionals must help educators develop techniques for calming children and helping them to modulate their emotional response to the classroom environment, and, thus, their behavior in it.

Help traumatized children learn to influence what "happens" to them;

Children who come from chaotic homes often fail to learn basic notions of cause and effect.[237] Helping them learn that obeying rules can result in good consequences and can actually help them succeed can be critical for these children. Educators can play a healing role in the lives of these children by helping them make these connections.

Prepare teachers to work with parents victimized by violence.

It is critical that teacher training help teachers understand the cycle of violence and its effects on adult as well as child victims.. This information may enable teachers to better partner with parents who may also be victims of violence.[238]

2. **Create clinical support systems for teachers where they can develop classroom strategies for addressing the needs of traumatized children.**

It must be recognized that teachers are often working with several traumatized children each day and need clinical supervisory input to develop classroom strategies based on the individual needs of their students. A further benefit of clinical input for teachers may be to assist those who themselves have suffered from abuse, neglect or trauma and who request support in handling their own responses to encountering similar children in their classrooms.

3. **Reevaluate school policies on confidentiality, curricula, and discipline in light of the needs of traumatized children.**

Child Abuse Reports (51As):

School policies on filing 51As, when appropriate, must be clarified to avoid stigmatizing children in the school setting or threatening the child's ability to trust adults at school. In most circumstances, parents should be informed prior to a 51A filing. After the filing, schools should work closely with parents, when appropriate, to support their parenting skills.

Protocols For Parental Interactions:

Schools must develop sensitive approaches for discussing a child's school experience and symptoms of trauma with his or her parent(s). These procedures are particularly important where the child's trauma originates in exposure to violence in the home, namely, as a witness to spousal battery.

Safety Planning:

Schools must be apprised of and, when appropriate, involved in safety planning for children and their families who require protection from batterers. *Policies on confidentiality must be clear and unequivocal.*

School-Wide Policies:

Policies must be developed that respond to traumatized children's need for predictability, sensitivity, and clear expectations. A predictable daily routine can contribute greatly to a child's feeling of safety in the school setting. Schools must also create consistent individualized response systems so that each child in the school knows how adults will respond to their behavior whether they are in homeroom or art class.

If, for example, a rule exists in a child's primary classroom that he or she can take a three-minute "breather" when frustrated, and the same rule exists in art class, the child can use the same coping strategies throughout the day. The child can thus assume greater responsibility for regulating his or her own behavior, which promotes a sense of self-control and feelings of safety.

When feeling stressed and near "losing control," the consistency of rules enables the child to handle his or her emotions more constructively by at least providing a stable, predictable environment in which they can manage their inner controls. Where the expectations of traumatized children are clearly established, they are better able to grasp the difference between life at school and life in the unpredictable and uncontrollable world in which they were traumatized. The end result is that the child has more energy and attention for important academic tasks and far greater likelihood of behavioral and academic success in mainstream classes.

4. Adapt school curricula to respond to the needs of traumatized children.

Researchers have only begun to look at trauma-specific methods for teaching core subjects like reading and writing. However, it is recognized that traumatized children can benefit from interactive teaching styles that accommodate their often-reduced capacity for attention. Moreover, recent studies of childhood trauma have found that the body "keeps score" of traumatic memories;[239] that is, the neurobiological effects of exposure to trauma are as tangibly impactful as their emotional consequences. This research may have vast implications for educational curricula, particularly as it attests to the value of physical education and arts programs in elementary and secondary schools. Innovative curriculum development in academic areas, such as reading that incorporates these new findings must be piloted and funded at the state and local levels.

Dr. van der Kolk encourages teachers to help traumatized children feel they can affect what happens to them by developing what he refers to as "islands of competence."[240] By encouraging these children to cultivate their strengths in non-academic areas ranging from physical education to theatre,[241] art and music,[242] educators may foster the development of self-confidence and a sense of mastery.

In addition, educators should incorporate instruction in conflict-resolution skills and the development of empathy into the regular education curricula.[243] As these children begin to develop the ability to adopt another's perspective, they are more capable of anticipating others' behaviors and responding accordingly. Traumatized children thus gain a feeling of control over what happens in their environment. Moreover, conflict-resolution skills help children understand and name their emotions, and thus gain a sense of mastery over them and a greater capacity for self-control.

Since researchers are only beginning to develop "best practices" for use by school personnel in their instruction of traumatized children, funding must be made available to enable psychologists to work closely with educators to identify these practices and the most effective school-based mental health interventions for serving this population. In their attempt to meet the needs of traumatized children, each school must respect the individuality of its particular culture and the confidentiality and safety needs of these children.

5. Develop protocols for early identification and services before children are at risk for discipline or school failure.

Mental health professionals must work with schools to develop tools that can assist regular teachers in identifying children who need referral for assistance or for evaluation, before their behavior problems affect their social or academic performance. These tools or protocols must be simple and not overly intrusive. For schools, the details of what caused the trauma are far less important than recognizing the symptoms of trauma in a child's behavior. Thus, as van der Kolk argues, it is more important for school personnel to consider "who is there for the child" in the school setting than to "become obsessed with the mechanics of abuse."[244]

Special education evaluations must consider the traumatic aspects of a child's disabilities and offer trauma-related services as necessary to address his or her individual needs. Yet educators must also work with community mental health providers to diagnose appropriately the symptoms of trauma. Schools must take caution not to misdiagnose traumatic symptoms as ADHD or other learning disabilities, or vice-versa.[245] Misdiagnosis can result in traumatized children struggling through special education programs that fail to meet their needs because they do not address the traumatic symptoms interfering with the learning process.

6. Fund collaboration at the local level.

Community-based mental health centers, trauma experts, and local child protection agencies must be given funding for the creation of networks of local services that can support schools and provide the resources they need to help each traumatized child succeed. These networks should facilitate the collaboration of those most immediately involved in the provision of services. It is important that teachers, the child's social worker, psychologist, therapist, guidance counselor, parents, and school administrators be able to collaborate directly, without fiscal or confidentiality barriers.

Schools should offer the families of traumatized children an opportunity to meet with local Family Support Teams that can assist them in identifying services they might need or want. Schools should be eager to participate on these teams when appropriate. Family Support Teams and services should not be located within schools. Families have the right to strict confidentiality and to normal interfaces with their children's school. The primary status of schools as educational settings must be safeguarded

SECTION V

Preventing the Hurt

...effective family-strengthening efforts will require commitment and active participation that literally shout, loudly and clearly to the public at-large, that reconnecting our most fragile families is the most important thing we can possibly do if we want to improve the life prospects of our nation's children.

Douglas Nelson, President, Annie E. Casey Foundation
Kids Count Data Book, 2000

CHAPTER 16

Family Support: The Critical Paradigm Shift

Families have traditionally relied on each other and on friends, neighbors and community groups for support and material assistance during difficult times. Today, families are experiencing unprecedented levels of stress. Many factors have resulted in parents having less time and resources to devote to their own children and families. Changes in family structure brought about by divorce, single parenthood, geographic mobility, and increasing numbers of mothers in the workforce have left families more vulnerable and in need of more support than ever before.[246] These changes have also left many families isolated, under increasing stress, and less able to provide support to each other.

For example, one study conducted by the Children's Defense Fund involved two-parent, non-minority families with mothers who had at least a high school education - families not traditionally considered at risk. Disturbingly, almost half of the families studied showed family stress and poor coping skills, poor parent/child communication, and delays in their children's development. [247]

It is often unacknowledged that many middle class families routinely receive "help" in raising their families. Paid babysitters, visits to private pediatricians, attendance at prenatal exercise classes at the local gym are all examples of family supports. Most middle-income families can afford to pay for these basic services. Few would dispute that these families benefit from the peer support offered.[248]

Lower income families have similar needs but may have difficulty obtaining similar support. Basic services such as healthcare, housing assistance, and employment may be lacking in their lives. Pressured with the additional stresses that poverty brings, these families can benefit greatly from help in coping with the daily challenges of raising children, and from services tailored to their individual needs.[249]

Very young parents face especially difficult child-rearing challenges. They typically have less money and personal resources than older parents, and their own needs for self-discovery and independence may conflict with their parental responsibilities. Family supports can assist young parents in recognizing and reconciling these conflicts. Educational opportunities that address these issues and support responsible parenting can be a lifeline to both teenage parent and child.

A 1997 survey of 3,238 Massachusetts families conducted by the Urban Institute's **National Survey of America's Families** revealed that parents in Massachusetts experience one of the highest stress levels in the nation.[250] **Two indicators in the survey are worth noting: parental aggravation and poor parental mental health.**

Parental aggravation was assessed using a scale that summed a parent's estimates of how often in the month prior to the survey interview he or she felt the child was much harder to care for than most, the child did things that really bothered the parent a lot, the parent was giving up more of his or her life to meet the child's needs than expected, and the parent felt angry with the child. On that indicator:

- High parental aggravation was reported in over 10 percent of all Massachusetts families. For those families living below 200% of the poverty level, the figure rose to nearly 21 percent compared with 13 percent for other poor U.S. families surveyed.

On the mental health indicator, parents were asked five questions about how often in the past month they had been a very nervous person, felt calm and peaceful, felt downhearted and blue, been a happy person, and felt so down in the dumps that nothing could cheer them up.

- Nationally, 17 percent of children lived with a parent whose survey responses suggested poor mental health, while in Massachusetts the figure was 25 percent. For Massachusetts children living in families with low incomes, however, nearly 32 percent lived with a parent who had symptoms of poor mental health.

Researchers now understand that one of the best ways to serve children is to serve parents also. Studies confirm that supportive networks contribute significantly to all parents' ability to raise their children.[251] When programs and services reach a parent early, and when parents are better linked to positive connections in the community, their children benefit. When individuals feel responsible for their communities and the safety and health of their residents, children also benefit. Corroborated by research, these common sense principles have led to a growing family support movement at the federal and state levels.[252]

The Family Support Philosophy

This Family Support movement is grounded in the belief that families function best when they can determine their own needs and how best to address them. Family support services work to strengthen families by creating opportunities to acquire the knowledge and skills they need and want to better manage the many demands placed on them.

Special features of family support programs and policies include:[253]

1. *Family strengths rather than deficits are the focus.*

   All people have strengths or the capacity for growth. By enhancing strengths, as well as addressing deficits, people become more able to deal with difficult life events, set growth-oriented goals, and achieve personal aspirations.

2. *Families can access support services and resources as needed.*

   Families themselves should determine what resources and services they need and receive. They should not be made to accept services that don't fit, just because they are the only available services. Services must be flexible and responsive and they must make families feel welcomed and valued.

3. *Family diversity is valued and respected.*

   Because families come from a variety of cultural backgrounds and life experiences, they respond differently to assistance and support. Services are offered and made available in ways that reflect the strengths of diversity.

4. *Parents and families are given opportunities to contribute to their own and their community's well-being.*

   Any meaningful effort to provide resources and services to families must provide ways for them to be a part of the planning, implementation and evolution of programs. Parents and youth must be encouraged and supported in their efforts to contribute to the community. They should be given opportunities to experience how their involvement can bring about change and contribute to their own well-being.

5. *All sectors of the community are involved in networks and collaborations whose unifying mission is to support families.*

   A helpful community is one that fosters social caring and "situation-changing" supports, as opposed to rehabilitation and "people-changing" services.[254] Ensuring that all children grow up in an environment that supports their healthy development is in everyone's best interest. Members of all sectors of the community have a role to play in supporting families. Each sector must make decisions that will support the positive efforts of the other sectors and ultimately enhance rather than impede family functioning. This requires open communication and a willingness to plan for long-term benefits, as well as short-term gains.

Traditional Services and Family Support

The philosophy of family support and the services grounded in that philosophy distinguish themselves dramatically from traditional services.[255] Traditional services offer only specific services or treatment with the expectation that the family will adjust to fit the program's requirements. Parents are rarely included in decision making about what service would be welcomed or beneficial. Program and funding sources often dictate types of services and eligibility requirements. Rigid office hours and waiting lists are typical the norm. Services emphasize deficits and tend to focus on the individual as opposed to the family unit. In most cases, intervention occurs after a crisis, and only when a family's needs intensify.

In contrast, family supports meet the needs of the family and child early on, before a crisis occurs and needs become greater. Family supports offer flexible help to meet basic family needs. The focus is on the family rather than strictly on the individual. Services build on family strengths rather than on family weaknesses. Outreach to families is paramount. Services are available on a drop-in basis and can be offered in a family's home or in home-like centers.

Parental Involvement in Decision Making

As stated above, families themselves should assist in the process of determining what services would be most welcome and beneficial. Communities in other states have successfully implemented parent involvement models. These models value child safety and well-being, engage families respectfully, and build upon existing family strengths to encourage and support lasting change. Two of these outstanding approaches are described below.

Individualized Courses of Action

The Edna McConnell Clark Foundation has been committed to the research and study of family support initiatives within communities through its Community Partnerships for Protecting Children Initiative. It has funded and supported communities willing to engage in family support philosophies and services. Four sites - Cedar Rapids, Iowa; Jacksonville, Florida; Louisville, Kentucky and St. Louis, Missouri – have developed partnerships in which civic and volunteer groups have joined with public agencies to increase community participation in strengthening families and keeping children safe.

In the St. Louis site, families are being served using an innovative parental involvement approach called "Individualized Courses of Action" (ICA).[256] Here the core focus is the family's actual strengths and underlying needs, as opposed to their immediate problem or crisis. The expressed needs of parents are addressed with services that are appropriate, not just any services that happen to be available. A "contract," also called an "ICA" defines how parents, service providers, and other parties can sign on to assist in meeting identified goals. Neighbors who agree to provide weekly respite care, or a local minister who agrees to counsel the family, would all be responsible parties to the agreement. A family conference in which the family's needs are fully identified could include the development of several ICAs involving a larger pool of natural family helpers.

Family Group Decision Making

Family Group Decision Making (FGDM)[257] is a new approach to working with families involved in the child protection system. A hallmark of the approach is the collaboration, communication and cooperation it fosters between the family and professional.

Since 1989, two primary models of FGDM have been practiced worldwide in child welfare: Family Group Conferences and Family Unity Meetings. The Family Group Conferencing model was developed and legislated in New Zealand in 1989 and has since been embraced by communities in Canada, the United States, Sweden, Australia and England. The Family Unity Model originated in Oregon in 1990.

The philosophy of these models is grounded in the belief that families, communities and government must partner together to ensure child safety and well-being. These models support the regular involvement of families in making decisions about their children's protection and safety. Conferences are held in which families play a key role. In the Family Group Conference model, professionals are excluded during the decision-making portion of the meeting. In the Family Unity model, professionals are included, however, birth family members can limit the participation of extended family members and others based on federal confidentiality laws designed to protect children from unnecessary disclosures.

New programs, adopting features of both these programs have been developed in California, Illinois, Kansas, Michigan, Vermont, Washington, Canada and the U.K. Each has adapted the model to reflect the needs and philosophies of local families and agencies. Interest in these models has been sparked by the alarming shortage of foster and adoptive parents, especially for children of color. Involving extended family in these meetings can increase appropriate placements of children within kin homes.

Critics of these family-centered practices are concerned that children's safety may be compromised if the decision-making role is turned over to the family. Others fear that families simply do not have the ability to make difficult decisions regarding the best interests of their children. Anecdotal reports, however, support the view that families are thoughtful and creative in identifying plans and solutions to meet their needs.

Every program implemented to date allows social work professionals or the court to veto family decisions if they place children in jeopardy. It is important to note that these family support models are not intended for situations in which a child's safety is in immediate jeopardy or where allegations of sexual or physical abuse have been made.

A benefit of these family support approaches is that they lead to an increase in voluntary self-referrals for treatment and support and, due to their preventive nature, a reduction of more serious cases over time. An appropriate balance can be struck between respecting the family's request for self-determination in pursuing services without additional help, and the need to monitor the family's progress and address any issues subsequently identified. Advocacy should be available, if requested and needed, to better ensure that the family obtains the services it needs.

The Effectiveness of Family Support

In 1994, the Minnesota-based McKnight Foundation funded the Ramsey County Community Human Services agency to conduct a project designed to reduce abuse and neglect and strengthen family functioning among high-risk families.[258] Families in the study had high risk factors associated with child abuse and neglect, but were not involved with the state child protection agency. Half of the families were assigned to the treatment group and were offered the opportunity to work with one of 39 local agencies participating in the project. Families worked with this agency to develop a service plan to help address some of their identified needs.

Families could use project funds to purchase a wide array of services, as long as they related to the family plan. Funds were used to purchase transportation, child or adult education services, respite care, health related services, individual counseling, parenting education, legal advocacy, and/or recreational opportunities. Families in the control group were not eligible to receive free consultation or services.

Comparisons between the treatment and the control group were striking:

- During the 30-month project period, out-of-home placement costs for the treatment group were 7.3 times less than for the control group - $24,638 compared to $180,133.
- Child Protective Services case openings during this period were substantially lower for the treatment group - 1.6 vs. 5.7 for the control group.
- Families in the treatment group were more likely to have been employed six months or longer - 60.4 % vs. 44.9%.
- During the 12 months following the program, the treatment group was less likely to report abusive behavior by a partner - 12.3% vs. 22.19%.

Based on the project's outcomes, the State of Minnesota in 1996 provided additional funds to enroll 100 new families. This phase of the project did not include a control group, but the state-funded Family Support Project provided essentially the same services to the high-risk families. Eight months following the project, differences emerged between those who received family support services and those who proceeded on a "business as usual" course.

- Parents were significantly less likely to report violent behavior among adult household members (8.4% vs. 24.1%), threats of violence (15.7% vs. 32.5 %), or frequent arguments between adults (21.7% vs. 37.3%).
- Parents were more likely to be employed (26.5% vs. 9.6%) and reported higher earnings.

The results of these demonstration projects are promising and document that family support services offered to high-risk families *not* involved with child protective services can reduce child abuse, domestic violence, and out-of-home placements, as well as improve employment status.

DSS Family Support Programs

Although the Department of Social Services' primary focus is to protect abused and neglected children, its mission also includes providing a range of services to support and strengthen families with children at risk of abuse or neglect. However, because of the stigma or fear of agency involvement in their lives, many families who would welcome support services are unlikely to seek them directly from DSS.

In contrast, studies show that high quality support services offered in and by the community can result in an increase in voluntary self-referrals from this group of underserved families and, therefore, a reduction of more serious child abuse and neglect cases over time.[259]

State funding does not currently support wide-scale family support efforts within DSS, however, the Department does play a role in working to reduce child abuse and strengthen families by funding local community initiatives. Three types of DSS programs or pilots that embrace the principles of family support are described:

Community Connections

Community Connection was established by DSS in response to the federal Family Preservation and Support Act of 1993. Working at the state and community levels, it was established to build a continuum of family support services in neighborhoods across Massachusetts, particularly to serve the needs of families *not* involved with child protective services.

It was largely modeled after Dorchester CARES, a 5-year federally funded demonstration project initiated in 1989 by MCC, working in collaboration with its local Boston partner, Federated Dorchester Neighborhood Houses. CARES was built with a commitment to **C**ollaboration, **A**dvocacy, **R**esource development (people *and* money), **E**ducation, and **S**ervices. During its ten-year history, CARES has developed independently into a continuum of supports that include: three neighborhood cooperatives offering parenting and social supports, educational opportunities, food and clothing pantries, childcare, and newborn home visiting. Within CARES, families can look to their own neighborhood and community for supports that are truly useful and respectful of family strengths and diversity.

Since federal funding provided to DSS, the state's child welfare agency, was inadequate to build a statewide family support network, it applied the research of James Garbarino and Massachusetts census data to target areas where risk factors for child abuse and neglect were highest.[260] A wide variety of family supports are now offered through 22 local Community Connection sites that function as local family support collaboratives.

Among the supports provided are: clothing exchanges and food pantries, parent education and support groups, drop-in centers, respite care, family nurturing programs, parent mentoring programs, and violence prevention activities. Services are grounded in family support principles and involve residents actively in planning for and carrying out programs and activities.

Community Connection sites have taken on the role of coordinating services in 22 of the 27 DSS area offices. These local collaboration involving multiple agencies, play a crucial role in coalition building, outreach to the community, coordination of services, and referral of children and families to appropriate local resources. Community Connections also works in partnership with other state agencies, such as the Departments of Public Health and Education and the Children's Trust Fund, to coordinate prevention efforts among state agencies and integrate family support concepts into child welfare practice.[261]

The Department of Social Services should be applauded for its leadership in implementing the family support collaborative model and its related programs. Funding and expansion of this network is now essential so that access to critical family supports can be made available to children and families statewide.

Family Based Services

As discussed in Chapter 8, the DSS has also initiated the Family-Based Services program, which combines family strengthening principles within a managed care model. In this model, established child welfare agencies compete to serve as the Family Based Service Lead Agency in their particular area of the state. These Lead Agencies arrange for services to DSS clients from a wide array of local resources. Increased family input in planning and designing these services, and increased use of community, grassroots, and other supports for families are key to this program. Local, culturally competent experts in child development, substance abuse and other clinical areas can be made available to the network.

Currently, every DSS Area Office utilizes Family Based Services. Open DSS cases are served, as well as cases involving Children In Need of Services (CHINS) referred by the courts. The services may be used to stabilize children in foster care settings, and in kinship, guardianship or pre-adoptive placements. Family Based Services can also be used for reunification and transitioning children and youth from group care settings.

Patch Programs

Another family support effort is the "Patch" Program, a shared decision-making, community-based pilot that works to build partnerships between the community, the Department of Social Services, and the Department of Youth Services. (The program originated in England where "patch" is a term for neighborhood.) The Patch concept calls on community residents and organizations to help support families and youth who are involved with these agencies.

A typical Patch team might involve a DSS caseworker, Patch coordinator, various service providers and a family clergyman. Together they craft a package of support strategies and services that might aid the child and family. Dorchester CARES in the city of Boston, and North Quabbin Community Center in the rural town of Athol are the only Patch pilot sites in Massachusetts at this time. Evaluation results are pending.

Specific examples of other state and private family support in Massachusetts that play a unique role in preventing child abuse and neglect are discussed in the next chapter.

RECOMMENDATIONS

1. **Expand "Community Connections" sites statewide, and build their capacity to serve a broad range of families, including voluntary referrals, cases screened out before or after DSS investigations, and low-risk cases active with DSS.**

   A budding infrastructure of family supports is developing in Massachusetts but its scaffolding is fragile. Currently, there are no plans to guarantee its stability or future development, or to contribute state dollars to support and expand the network of Community Connections sites. Federal dollars have been the only source of support for these programs since the federal Family Preservation and Family Support Act was passed in 1993, and these are only secure until 2002. Massachusetts must work *now* to ensure a smooth transition to state funding and the expansion of this vital family support structure across the state.

2. **Establish a statewide system of local Family Support Teams to be coordinated by "Community Connections" sites.**

   As described earlier in the report, all families that request them should have access to support and consultation from Family Support Teams operating at the local community level. These Teams of local professionals and family advocates would coordinate "family conferencing" as a tool to assist families in assessing their own needs and addressing them through a range of local services and supports. In addition to direct voluntary referrals from families in the community, these Teams could also be made available to: families within DSS that are identified as low risk; families reported to DSS but screened out without any investigation; and those families investigated by DSS where abuse or neglect is not substantiated.

3. **Ensure collaboration and coordination among state and private family support and service providers through a specific state mandate backed with sufficient resources and quality assurance.**

This goal could be achieved through the establishment of a Governor's Cabinet on Children and Families. The Cabinet would transcend state department and secretariat boundaries, and nurture a flexible system for effective administration of programs for children and families. The Cabinet could be convened by the Governor or his designee and include representatives from the Executive Office of Health and Human Services, and from all other State Offices or Departments whose mandates include serving children and their families.

The Cabinet would actively promote the principles of family support, and coordinate training in family support practices for state and private service providers. The Cabinet would be assisted in fulfilling its mission through an Advisory Council composed of legislators, parents, child welfare/family support advocates and providers, and officials from local cities and towns.

CHAPTER 17

Child Abuse Prevention: Within Our Reach

Other state agencies, including the Department of Public Health, the Department of Education, and the quasi-public Children's Trust Fund, are each involved in the development of family supports that serve at-risk populations or the general public. Private sector groups are also providing leadership in developing innovative and effective approaches. Taken together with proposals put forth in the **State Call To Action**, these can become the foundation upon which a truly statewide, comprehensive, and coordinated system can be built to strengthen our state's families and prevent the abuse and neglect of its children.

Other State-Based Prevention and Family Support Efforts

Department of Public Health

The Department of Public Health (DPH), through its Bureau of Family and Community Health, has a number of prevention and family support programs providing services for low income and vulnerable families. The **First Link** program provides universal screening of newborns and families at high risk of adverse health or developmental outcomes. Referrals to needed services and supports are also provided. DPH's **First Steps** program provides home visitation to pregnant women and families of newborns and young infants in selected cities and town who have been identified as at higher risk. The Department's **Home Visitation Program** also provides home visitation for new parents under the age of 20 with a child under the age of 6 months.

The **Early Intervention Program** identifies children who experience or are at risk of developmental delay due to physical or environmental factors. Through home visits, parent support groups, referral services, and parent training and education, these services work to improve developmental outcomes for children. Currently there are 65 Early Intervention programs across Massachusetts. Other prevention programs that help to reduce child neglect include DPH's **Healthy Start Program,** which reduces financial barriers to early, comprehensive and continuous prenatal care for low income uninsured women, and the **WIC** program which provides supplemental nutrition to women, infants and children.

Department of Education

The Department of Education (DOE) is committed to improving children's success in school through early intervention efforts directed at families with children from birth through age four. Its **Family Network Program** operates in 41 sites that cover 162 communities. Through local centers, families can participate in programs to improve parenting skills and reduce isolation, and enroll their children in playgroups and other activities. Referral to other appropriate community supports is also provided.

DOE also funds the **Parent-Child Program** in Pittsfield where home visitation by para-professionals is made available gratis to at-risk, low-income and low-education level parents of young children. Families can receive up to two years of home visitation per week. The focus here is to model effective parenting. The Pittsfield program, in operation for twenty years, has documented other important benefits for participating families, including a lower student dropout rate and improved student test scores.[262]

Massachusetts Children's Trust Fund

The Children's Trust Fund currently funds a number of community agencies and programs serving families. Programs include parenting education and support programs, and initiatives aimed at strengthening the role of fathers. The Trust Fund also funds **Family Centers** in 6 Massachusetts communities. These sites target parents of children up to age 6, coordinate services, and refer families to appropriate local providers.

Since its inception, a major focus of the Trust Fund's work has been to promote **newborn home visitation**. Though the effectiveness of home visitation needs to be further documented nationally through larger scale evaluation research, some studies are pointing to improved outcomes for children and mothers involved.

For example, evaluation of home visiting services that conform to the model promoted by Health Families America (HFA) found that *families enrolled in home visitation are two to three times less likely to maltreat their children* than comparable families who are not enrolled.[263] Prevent Child Abuse America, home of the Healthy Families America program, reports results from several states (Oregon, Florida, Virginia, Arizona and Tennessee) that show *improved immunization rates and better links to medical services for children* whose parents participate in HFA-type home visiting programs.[264] According to the latest survey conducted in 2000 by Prevent

Child Abuse America, over 40,000 families across the country have received these home visitation services.

Evaluation of the Prenatal and Early Childhood Nurse Visitation Programs developed by Dr. David Olds has shown enduring benefits among poor, unmarried women. They averaged *fewer subsequent pregnancies, a longer time between the births of their first and second children, fewer months on welfare, fewer behavioral problems related to substance abuse, and fewer arrests.*[265]

With support from Healthy Families Massachusetts - an ad hoc committee of state agencies and private groups promoting newborn home visiting - the Children's Trust Fund has taken the lead in successfully advocating for voluntary home visitation for all new parents age 20 and under in Massachusetts. Strong support from legislative leaders has resulted in an increase from $5 million dollars to $16.1 million dollars for newborn home visiting within a five-year period.

Healthy Families Newborn Home Visiting in Massachusetts is funded through the Children's Trust Fund and administered in partnership with the Massachusetts Department of Public Health. It includes 30 lead agencies statewide that offer home visitation programs, with additional subcontracted sites bringing the total to 60 program sites. Since its inception over 400 home visitors, sometimes referred to as "family advocates," have provided services to approximately 6,500 families. Caseloads are set at 15, although this can vary depending on the types of family issues involved.

Parents 20 years and under can participate in the program if they are first time parents, with a child under one year of age at the time of enrollment. Services can continue until the child reaches the age of three. Participation is voluntary in this primary prevention model.

Ninety hours of basic training through an established core curriculum is required of all home visitors. It is offered statewide on a regular basis along with other standardized trainings. Currently, an independent evaluation involving Healthy Families participants is being conducted by Tufts University. Final evaluation results are still pending.

Prevention and Family Support in the Private Sector

Since the late 80s, child and family advocates in Massachusetts have been working to promote a shift away from crisis-driven interventions toward a proactive promotion of child and family well-being. The Special Committee on Family Support, an ad-hoc group of these advocates, has articulated in its seminal report, **From Crisis to Opportunity**, a vision in which families and their communities play the central role in organizing programs and allocating resources that genuinely support families.

In its surveys and papers, the Committee has identified strength-based programs across the state that provide powerful supports to families despite their generally low and unstable budgets. Among the supports provided by these programs are: flexible, drop-in childcare; parent social activities; playgroups; teen centers; health care and education; substance abuse prevention; domestic violence awareness and services; and advocacy.

More and more researchers are improving their methods of evaluating the impact of prevention and family support programs on parents and children. Although refining our knowledge about effective strategies should be ongoing, there are several prevention and family support programs that have a solid history of successfully helping parents and children. Many are effective from both a clinical and fiscal perspective.[266] A description of selected programs follows:

Parents Helping Parents

Effective family support programs include self-help/mutual-aide groups, such as **Parents Helping Parents (PHP)** where parents under stress are served anonymously and supportively. This unique resource assists parents who are isolated, overwhelmed, or afraid of their anger towards their children. Groups are led by a trained facilitator (unpaid), in partnership with a parent leader from the group. Churches and local agencies donate meeting space. Over 50 groups are currently meeting in communities across the state each week, including four prison groups that serve incarcerated parents.

The concerns parents bring to their PHP group are varied, as is the severity of their needs. For some parents, PHP serves as a prevention resource to help them when they feel isolated, frustrated, and lack trusted friends to talk to about parenting concerns. For others, PHP can be a lifeline when serious parenting problems exist, for example, when abuse or neglect has occurred or children have been removed from their home. Approximately half of the organization's members have been involved with the Department of Social Services.

Groups that have a "mixed membership," in terms of severity of parenting issues, usually work very well. Parents with less severe problems discover that their concerns are less traumatic that they once thought. They are then able to gain perspective and discover that their experiences can be helpful to others. Parents with more severe problems are relieved to be welcomed with respect by others in the groups. They come to realize that despite the negative parenting behaviors, e.g. yelling, hitting, that brought them to the group, they can learn new skills and a deeper understanding of their own unmet needs. Through the compassion of others, they come to see themselves as worthwhile people in their own right and, eventually, as a support to others. This dynamic allows some of the neediest parents to gain hope and appreciation for the strengths they never knew they had.

Evaluations of this self-help approach have confirmed several benefits, including:[267]

- statistically significant and immediate decrease in frequency of physical abuse after joining the group;
- decrease in frequency of verbal abuse, improving with length of stay in the program;
- greater parental self-esteem;
- less social isolation;
- increased ability to handle stress; and,
- better understanding of children and their needs.

This approach is cost effective as well. PHP weekly support groups cost approximately $600 per family per year. Costs associated with recruiting and training of volunteer group facilitators, staffing the PHP support phone line, and promoting the service statewide are met through private funds and a small state grant from DSS.

Parent Aides

One of the seminal evaluations of child abuse services, the 1974 Berkeley Planning Study, found results that are still relevant today.[268] It dealt with the effectiveness of the lay visitor or **parent aide model**. Parent aides are trained, professionally supervised individuals, volunteer or paid, who assist parents under stress or those at risk of abuse or neglect. The one-on-one relationship is parent-focused, non-judgmental, non-authoritarian and nurturing. Parent aides work in the home to develop parental self-confidence and esteem; home management, problem solving, communication and coping skills; and the use of appropriate community resources.

The study found important results among parents who were in traditional treatment or counseling for at least six months, and who received parent aide services in PHP type self-help groups. **These parents were most likely to show improved functioning by the end of treatment and had the best chances of reducing the likelihood of future abuse.**

Benefits for parents included:
- more positive attitudes towards their children;
- increased awareness of child development;
- improved ability to talk about problems and handle crises;
- more constructive ways of channeling anger;
- an increased sense of independence;
- and improved self-esteem.

The study also pointed out that those services that proved more effective also tended to be those that were the least expensive.

Here in Massachusetts, parent aide services essentially provide home visitation services, but to a population of families who have already been reported for abuse or neglect and who are under the care of DSS.

These private services funded by DSS have just completed their first year under the Lead Agency Initiative described earlier in this report. While the newborn home visitation services provided under Healthy Families operate under a flexible strength-based model, the DSS-funded Parent Aide programs struggle under the fiscal constraints of the managed care model. A discrepancy exists between the philosophy of strength-based, family-centered assessment and services espoused by DSS Central Office and the traditional deficit-based model that has been practiced historically within local DSS offices, and social services in general.

The fiscal charge given to the Lead Agencies sometimes undermines implementation of the Parent Aide model, which is fundamentally grounded in the development of a relationship between the Parent Aide and parent. The relationship and trust building that are so essential to the success of this parent support cannot be accomplished within rigid, limited timelines. Outcome measures that are limited to a short time (3 months of service) are simply unrealistic and inappropriate for many families who could make significant gains given the chance to work within an uncompromised Parent Aide model.

Many Parent Aide programs report that, despite waiting lists, they are now providing lower levels of service than they had been historically. This threatens the ability of programs to retain experienced, trained staff, maintain program quality, and, in some cases, even keep their doors open. The Association of Massachusetts Parent Aide Programs, a longstanding voluntary organization of Parent Aide programs, continues to advocate for the integrity of its model even within the managed care system. If managed care is concerned with meaningful client outcomes and reducing costs in the long term, it cannot afford to reduce Parent Aide services in the short term.

Family Nurturing Program

The Family Nurturing Center of Massachusetts helps build nurturing communities where children are cherished, families are supported, and private and public policies promote healthy human development. It develops and pilots innovative family support and educational programs, then mentors others who adapt them for use within their own organizations and communities. By working in partnership with others, the FNC changes attitudes and practices of both families and the professionals who deliver services to them. Using this approach, the Center has successfully spread nurturing values and creative new family support programs across Massachusetts.

One of the cornerstones for the work of the Family Nurturing Center is the **Family Nurturing Program**. The Family Nurturing Programs are validated, internationally recognized programs that promote nurturing relationships among all family members while building community connections to support positive parenting attitudes and behaviors. Developed over twenty years ago by the National Institute of Mental Health and child abuse researchers Bavolek and Comstock, the Nurturing Programs are now operating in the U.S., Canada, Mexico, Europe, South America, and Israel.

Nurturing Programs are weekly classes that families, adults and children take together. Programs are held in convenient, safe and nurturing environments and involve adults and children in interactive, fun, age-appropriate activities that promote nurturing attitudes and behaviors. Programs range in duration from 9-23 sessions and address the following topics: communication skills, identifying and expressing feelings, nurturing discipline techniques, use of personal power, managing conflict and confrontation, promoting positive self-esteem, empathy, alternatives to physical punishment, and information about age-appropriate expectations for children.

Nurturing Programs are targeted to: prenatal families, teen parents, parents of school age children, parents with infants and toddlers, families struggling with substance abuse treatment and recovery, foster and birth families, Spanish speaking families, Cape Verdean Creole-speaking families, and more recently, the Father's Nurturing Program.

Extensive evaluation has shown the program to be effective in changing both negative parenting attitudes *and* behaviors.[269] Families that participate demonstrate:

- significant increase in family cohesion, communications and organization.
- marked decrease in family conflict.
- significant decrease in reliance on abusive discipline techniques.

The success of this approach can be seen further in the high numbers of families who begin and complete the programs and who report high rates of satisfaction. The programs are free for the families and most often include a meal and transportation. Program costs are underwritten through private and state grants.

The Family Nurturing Program was initially piloted in Massachusetts in 1990 as part of a five-year, federally funded demonstration project called Dorchester CARES, of which MCC was a founding partner. Today, the Family Nurturing Center works with organizations statewide to provide direct nurturing programs to families, and extensive training and consultation to communities interested in developing Nurturing Programs in their area.

As more and more families and community groups experience the success of Nurturing Programs, the demand for more programs increases. Currently, there are waiting lists for many community programs and in many places there is limited access to programs. Clearly, this proven effective family support program needs to be expanded where it currently exists and developed in other communities statewide.

Shaken Baby Syndrome Prevention

In 1996, six months before the highly publicized death of 17-month-old Matthew Eappen in Massachusetts, MCC launched its statewide **"Never Shake a Baby" Campaign** to reduce infant death and disability due to Shaken Baby Syndrome (SBS). Through television, radio and the print media, parents and caretakers have been offered information about the devastating results that can occur from this type of assault on an infant or young child. Coping with infant crying and fussiness, often the triggers of SBS, has been an important feature of the Campaign's message.

Now operating under MCC's "Prevent Child Abuse Massachusetts" (PCA) program, the campaign has reached thousands of parents directly through brochures and printed materials, requests on PCA's **800-CHILDREN** line, and through campaign information distributed by hospitals, clinics, birthing classes, schools, libraries, etc. Over 500,000 teaching brochures have been distributed throughout Massachusetts and in several other states (Wisconsin, New Hampshire, Delaware, etc.) that have adopted the brochure as their core teaching tool.

As it moves to the next phase of its campaign, PCA Massachusetts is seeking to replicate a successful, eight-county SBS prevention pilot effort in Western New York State. Coordinated through Children's Hospital of Buffalo, the effort targeted new parents within hospitals with a combination of written SBS information, video presentation, and signed parental statement acknowledging understanding of the information.[270] The counties have documented a *75 percent decrease in reported SBS* *cases*. Prior to the effort, one case was identified every seven weeks; the number has now dropped to one case every eight months.

Brockton and Haverhill are two communities that have taken the lead locally to reduce SBS injuries and death. The former effort was launched by the District Attorney's Office in collaboration with local hospitals, agencies and schools; the latter by the mother of an SBS victim who works in her community to educate medical professionals, school children and the general public.

Massachusetts does not currently have a formal curriculum in place to teach middle school and older children about SBS prevention. However, such tools have been developed using demonstrations, video, and discussion materials to help young teens learn about SBS as they begin to take independent care of their siblings and other children. This type of curriculum is seen as an effective way to reach future mothers *and* fathers.

Child Sexual Abuse Prevention and Treatment

Currently, Massachusetts lacks a comprehensive, statewide strategy to reduce sexual assaults against children and to address the critical lack of effective evaluation and treatment resources for both child victims and for child, youth, and adult offenders.

Successful prevention and treatment strategies in other states should be accessed and replicated. For example, **a coordinated effort in Vermont resulted in a reduction of proven cases by 51 percent** between 1990-1998. Partnerships among the State child protective agency, law enforcement, the Attorney General's office, child advocacy groups, public health agencies, and the media were cited as instrumental in this dramatic reduction of child sexual abuse. Through a recently launched, large-scale public education campaign conducted in partnership with non-profit organizations, Vermont seeks to identify even more cases of unreported child sexual abuse.[271]

Although many Massachusetts schools do provide prevention education curricula around "stranger danger" issues and "good touch/bad touch," it is not clear just how effective these programs are in actually protecting children when they are in threatening situations. Although they do increase awareness, it has been shown that these programs are more effective for older children - younger children require more frequent exposure to program materials. Though some children exposed to these programs may have benefited from increased awareness about sexual abuse, it is not evident that children who actually experienced threats and assaults were able to limit their seriousness.[272] Though prevention curricula should be part of a comprehensive strategy, they cannot be the center of it. Other complementary strategies will need to be considered as part of an effective statewide prevention effort.

In developing a comprehensive plan to address child sexual abuse, Massachusetts should seriously explore models that can address the population of offenders who wish to stop their offending and need support to do it. Some states have initiated broad public awareness campaigns aimed directly at sexual abusers. Through a special hotline established in Vermont, for example, sexual abuse perpetrators were guided to seek treatment and to accept responsibility for their actions. Outcome data from the Vermont effort should be carefully reviewed.

Massachusetts should also explore ways to involve the media as partners in educating the public about the impact of child sexual abuse. Such partnerships could help educate citizens about how to talk to their children about sexual abuse; signs to be aware of in both child victims and adult perpetrators; how to address factors that make disclosure among children difficult. These can be complex dynamics, but with clear and consistent public education messages, many families and communities can be strengthened in their vigilance against this devastating threat.

RECOMMENDATIONS

1. Fund universal, voluntary newborn home visiting for all new parents.

Massachusetts can be proud of its success in making available newborn home visitation support to all parents 20 and under that seek it. The state must now move to benchmark when and how it will phase in universal home visitation for all new parents, irrespective of parental age.

2. Expand funding for proven effective family support programs so they are accessible to all Massachusetts parents who seek them.

Family supports that have documented their effectiveness in preventing child abuse and neglect and in reducing the stresses associated with child maltreatment must be expanded where they currently exist and their availability extended statewide.

3. Expand Shaken Baby Syndrome prevention efforts.

Massachusetts should replicate efforts that have succeeded in reducing infant death and disability due to Shaken Baby Syndrome. Initiatives aimed at educating new parents within birthing hospitals, and special outreach to young men - the most frequent perpetrators of SBS - should be implemented. All state agencies involved with parents and children should incorporate SBS prevention education into their training and direct service programs.

4. Establish a statewide Sexual Abuse Prevention and Treatment Strategy.

Massachusetts must develop a comprehensive, coordinated, statewide strategy to effectively reduce sexual assaults against children and to address the critical lack of effective evaluation and treatment resources for both child victims and for child, youth, and adult offenders. Public education efforts involving the media should be an integral part of the strategy. Such coordinated efforts, in Vermont, for example, have reduced proven cases by

51 percent over a decade. Massachusetts should set a similar goal and work to achieve it.

SECTION VI

Taking Action

In the middle of difficulty, lies opportunity.

Albert Einstein

CHAPTER 18

Social and Fiscal Costs of Child Abuse and Its Consequences

Research suggests that abused and neglected children become society's most disabled, dysfunctional and dependent individuals. Increasingly, child maltreatment appears to be the common denominator underlying our most serious social problems - from delinquency and runaway behavior in adolescents, to the violence and sexual crimes of adults. For many families, child maltreatment and family violence become patterns of behavior that are repeated in each new generation. The financial costs to our society to treat, harbor, prosecute, and incarcerate these victims is growing each year. *The cost to our children and future generations is far greater when we measure the loss in human potential, productivity, and well-being.*

Links between Abuse/Neglect and Juvenile Delinquency

A recent report by the Massachusetts-based Citizens for Juvenile Justice documents that children known to the Department of Social Services are at very high risk of becoming the future population of troubled youth served by the State's Department of Youth Services (DYS). It is a sobering fact that **over 50 percent of juvenile offenders served by DYS have previously been abused or neglected children under the care of DSS**.[273] Consistent with the increase in abuse and neglect in Massachusetts over the past decade, the DYS population has increased nearly 100 percent since 1992.[274]

Increase in the numbers of troubled youth and their previous status as DSS clients makes it clear that our state is failing to provide the high quality and consistent care, treatment, and other services required to effectively address the needs of many of these traumatized children.

Overwhelming numbers of adolescent runaways, teens involved in delinquent acts or violent behaviors, and adult criminal and sexual offenders report childhood histories of physical battering, emotional abuse and sexual exploitation. Researchers have used interviews, case file analysis and reviews of court and protective services records to determine the prevalence of maltreatment in the lives of incarcerated adolescents. Results consistently reveal a history of recurring and often severe maltreatment in the childhood of delinquent teens.[275]

A 1998 Boston University study concludes that **children who are abused and neglected are 1.8 times more likely to be arrested as juveniles, and 1.5 times more likely to be arrested as adults,** than children who have not been exposed to abuse or neglect.[276] This is an alarming trend, as the Commonwealth of Massachusetts predicts a 24 percent increase in the adolescent population between 1995 and 2005.[277]

Without intervention to stop the trend of juvenile incarceration, we will continue on the path of building more prisons for our abused/neglected children and the adults they will become rather than investing in prevention and treatment options that would improve their opportunities for success.[278] As Margaret Mead has stated aptly: "The solution of adult problems tomorrow depends in large measure upon the way our children grow up today. There is no greater insight into the future than recognizing when we save our children we save ourselves."

Links between Child Abuse and Adult Disease

Previous studies show that abused children, if untreated, can grow up to suffer behavioral and emotional difficulties. To compound these problems, new research documents that overall, abused children grow up to suffer from comparatively very poor health as well. Thirty percent (30%) of abused children in one study were found to have chronic health problems.[279]

Childhood sexual abuse, if untreated, can also have ramifications that affect the child physically later in life. For example, women who were sexually abused in childhood are more likely to suffer from gastrointestinal and/or neurological problems. They utilize health services at a rate three to ten times more than women who have not suffered such abuse.[280]

Numerous clinical studies also show that a disproportionately large number of women with alcohol problems report they had been sexually or physically abused during childhood. The research varies in identifying the reasons for this link, but several studies hypothesize that isolation, grief, or anxiety resulting from the trauma of their abuse or neglect may be responsible.[281]

The established relationship described earlier between multiple risk factors for adult heart disease, cancer, chronic lung disease and liver disease, and the extent of childhood exposure to emotional, physical, sexual abuse and household dysfunction is yet another example of the persistent impact of this public health problem.

Links between Child Abuse/Neglect and Welfare Dependency

Although child sexual abuse does not only happen to poor children, as would be expected, the rate is higher among children living in dangerous neighborhoods or with adults who abuse drugs and alcohol.[282] In turn, sexually abused children are more likely to have issues that could lead them to dependency on welfare. For example, a sexually abused girl is more likely to become a teenage mother or to drop out of school than a teenager who is not sexually abused.[283] Growing evidence shows that a disproportionately large number of women on welfare were sexually abused as children.[284]

Fiscal Costs to our Nation

The human and social costs of abuse translate into staggering fiscal costs for society. After the abuse has occurred, we pay for emergency medical care, investigation, and foster placement of child victims, therapeutic, rehabilitative and special education services. In the long term, the costs for crisis and emergency shelters, juvenile detention, adult institutionalization and incarceration are added to the bill, along with health care costs associated with major adult diseases related to abuse and trauma exposure in childhood.

For example, recent data indicates that medical costs alone can exceed $1 million dollars for the first years after a Shaken Baby Syndrome injury. Many of these SBS victims require ongoing medical, physician, and educational therapy, and a significant proportion will be completely dependent upon others for lifelong custodial care. Unpublished data from the Western New York Shaken Baby Education Project indicate that the medical costs for 64 percent of SBS victims are borne by the State of New York under Medicaid and other state-sponsored programs.[285]

Each year, the United States spends approximately $30 billion dollars on services for abused children, their families, and foster care families.[286] The American Humane Society and Prevent Child Abuse America conducted a study in 1994 to estimate the costs of child abuse and neglect.[287] The study reported that for victims of abuse the cost per family for counseling was $2,860 per year; annual costs were estimated at over $800 million dollars for the only one in five victims nationally who it was estimated actually receive counseling services.[288] Other estimated costs totaling nearly $8.5 billion for one year alone included:

- $ 3.5 Billion for Foster Care
- Almost $1 Billion for Specialized Service Facilities
- Almost $3 Billion for In-Patient Mental Health Facilities
- $ 240 million for Family Preservation Services

These figures do not include costs associated with investigations, family supervision by child protective services, or long-term impairment, such as loss of future earnings, drug and alcohol treatment, juvenile court proceedings, substance abuse counseling, special education and other cost that are directly related to the abuse and neglect of children.[289]

A second study, conducted by the National Institute of Justice (NIJ) in 1996[290] was the result of a two-year effort among various disciplines to measure the costs and consequences of crimes against persons in America. The study considered both direct costs of victimization, such as medical expenses, lost earnings, and public programs for victims. It also examined the indirect costs of crime, such as pain and suffering and the diminished quality of life faced by crime victims. Total direct and indirect costs of violent crime amounted to $426 billion dollars. Violence against children accounted for $56 billion dollars, or 20 percent of the direct costs, and 35 percent of the combined direct and indirect costs of crime. The breakdown of costs was as follows:

- $ 9 billion - Rape
- $14 billion - Other Sexual Abuse
- $24 billion - Physical Abuse
- $ 9 billion - Emotional Abuse

In order to reduce these staggering human and fiscal costs, an unparalleled commitment must be made to **ensure effective treatment services** for abused/neglected children and their families *as soon as they are identified*. It must be matched, however, with a parallel commitment to **strengthen our current state systems** charged with the care and protection of these children. The "third leg of the stool," without which the other two will fall, is the commitment to **significantly expand family support and prevention programs** that can keep families from failing and children from being damaged *in the first place*.

These three must not be viewed as separate and competing propositions. They are inextricably bound to each other and are fundamentally tied to our success in ending the unjust and unnecessary abuse of our children's bodies, spirits and hopes.

CHAPTER 19

Options for Funding Reform

According to Bear Stearns investment broker Ron White, "Investment in child abuse prevention and treatment provides government and society with estimated rates of return that would make a venture capitalist envious." As we have made clear in this report, child abuse and neglect have a tremendous impact on society, with victims of child abuse more likely to fail at school, engage in criminal behavior later in life, and costing taxpayers millions of dollars in treatment for mental illness, physical and emotional disabilities and alcohol and drug addictions.

Massachusetts is currently enjoying an almost unprecedented period of economic prosperity. This is an ideal time to consider what the public sector's role must be in supporting child abuse prevention efforts and treatment for abuse and neglect victims.

To date, sufficient funds have not been allocated to prevent the abuse and neglect of our nation's children, a public health crisis of significant proportions. While for every death attributed to cancer, America spends $794 in prevention, intervention, and research; for heart disease, $440; and for AIDS, $697, for every death attributed to violence, we spend a mere $31.[291]

Adequate resources exist in Massachusetts to address the child abuse crisis in our state. The following funding streams have been identified and should be explored further as possible sources to implement recommendations of the **State Call To Action** recommendations.

Potential Funding Sources

Crime Victim Compensation Fund

The Victim Compensation Fund has applicability to minors who are victims of abuse, and victim witnesses to violence. Currently victims of crime are entitled to receive up to $25,000 from the Victim Compensation Fund in order to pay for their medical or psychological treatment. The fund can be used as a last resort when insurance or Medicaid benefits have been depleted and ongoing treatment is needed. Children who witness violence can make a claim through their protective parent or guardian and receive a portion of the award. Historically, the fund has not been tapped to support multidisciplinary assessments of abused and neglected children, but proposed federal regulations relating to victim compensation funds provide for this coverage. The Massachusetts Attorney General's Office has expressed interest in drafting legislation to amend the current state statute and regulations in order to expand coverage for multidisciplinary assessments.

Distinct Entitlement for Traumatized Children

Massachusetts is currently experiencing a crisis in child psychiatric services. Traumatized children receiving Medicaid coverage have a need for services that far exceeds the needs of other children receiving Temporary Assistance for Needy Families (TANF) aide. A separate entitlement for traumatized children through a higher capitation rate for these children is necessary. This capitation rate could be used to carve out services for this special group when negotiating contracts with service providers. This would vastly increase the funding pool for this high-risk population.

Expanded Medicaid Coding

Medicaid codes currently do not provide for the billing and payment of coordination and collaboration among professionals that are so crucial to multidisciplinary assessments. Adding new codes to pay for these services can be done with operational ease, and does not require time-consuming legislation.

Private Insurance Carriers

Mental health insurance parity legislation has recently passed in Massachusetts. The law provides full mental health insurance benefits for children (and adults) who have biologically-based brain disorders, such as mental illness and bipolar disorders. The law also provides that insurers provide a minimum of 60 days of inpatient care and 24 outpatient visits for non-biologically based disorders, such as adjustment disorders, which can be common among abuse victims.

Blended Funding

Agencies need to break down barriers so that a child can receive what he or she needs without the constraint of internal regulations that may prevent funding due to a technicality. Interagency agreements to blend funding streams are now crucial so that the impact of the money spent on each child is maximized. For example, DSS, the Department of Medical Assistance, and the Massachusetts Behavioral Health Partnerships have jointly created transitional care units at the Franciscan and MacLean Hospitals. These supervised residences serve children and adolescents who would otherwise have prolonged stays in the highly restrictive environment of a hospital ward.

Community Fundraising Initiatives

Many child abuse prevention/treatment and family support initiatives have been successfully supported through the creativity and commitment of community non-profit boards. Working with concerned citizens, businesses, churches, local foundations and other philanthropic groups, they have complemented State and Federal funds. The Children's Advocacy Center of Barnstable County, for example, serves child victims of sexual and physical abuse and is located in a lovely home donated and furnished by local merchants and residents. Board members from the community meet to discuss fundraising and ways to improve the experience of children at the Center.

In Florida, local Child Protection Teams (CPTs) raise a significant percentage of their annual budgets through the efforts of their local communities. This represents the best example of how state and local partnerships can take joint responsibility for vulnerable children and families.

Federal Funding

The federal government has increasingly begun to recognize the value of comprehensive prevention initiatives that promote healthy development and reduce a variety of social problems. Several initiatives, through an array of Federal government programs, have allocated funds to the states to encourage and support programming. In March of 2000, the Child Abuse Prevention and Enforcement (CAPE) Act was signed into law with an appropriation for each of the states. In addition, many states use their Temporary Assistance to Needy Families (TANF) funds to support and expand community-based family support programs. Currently, research is underway to determine how these funds could be applied in Massachusetts to support the recommendations.

CHAPTER 20

Next Steps

With completion of the **State Call To Action**, the Summit Initiative moves to its next phase. Although the coalition building, data gathering, discussion and agenda setting will continue, the main new focus during the next year and beyond will be to engage an even larger constituency to support implementation of the proposed agenda.

In the months ahead, MCC is committed to providing leadership around the following objectives:

1. **Education and mobilization of:**
   - policymakers and advocates, including State Administration officials, legislators, public and private child welfare leaders, and family support advocates;
   - leaders of faith-based groups, multicultural leaders and groups, and business representatives;
   - citizens including, members of MCC's Campaign For Children, and those who have been affected by abuse and neglect.

2. **Dissemination of the Call To Action through the media, including:**
   - Editorials, op editorials, news, and feature stories in major newspapers and community weeklies;
   - Articles in selected magazines and professional publications;
   - Television and radio presentations.

3. **Implementation of the Call To Action by convening:**

   - The "Summit Work Group on Funding" to document total State, Federal and private dollars required to implement recommendations.
   - The "Summit Work Group on Legislation" to draft child protection and family support legislation and to secure funding for implementation.
   - The "Summit Work Group on Child Sexual Abuse" to review successful prevention and treatment models in other states and to develop recommendations for actions.

4. **Education of Candidates During the 2002 Massachusetts State Election Season:**

   - Ongoing public opinion polling, with published results, so citizens can determine voter priorities for children;
   - Candidate briefings to secure endorsement of the **Call To Action** and its recommendations;
   - "Kids and the Candidates" questionnaires and published results of candidate responses, so citizens can decide for themselves when choosing their elected officials. "Who's for kids, and who's just kidding?"

Conclusion

Massachusetts Citizens for Children knows from first-hand experience throughout its 40-year history, that the process of working for meaningful change is challenging and that outcomes are not always certain. However, there is a confluence of factors in Massachusetts and in the fields of child protection, family support, and child abuse prevention that makes this a time for opportunity and hope.

Can we achieve the kind of reform that will translate into improved lives for the vulnerable children and families of our state? We believe we can and that, through the collaborative efforts of all the many advocates for children who have been a part of this Summit process, we are collectively well positioned to take on and succeed at the challenge.

We look forward to a time soon in the future when the State of Massachusetts and all its citizens can repeat in truth the words of John F. Kennedy who, upon signing legislation for children, stated:[292]

> ***We can say with some assurance that, although children may be the victims of fate, they will not be the victims of our neglect.***

Endnotes

---

[1] Address, Testimonial Dinner for Congressman John Dow, Sterling Forest, New York, May 2, 1965

[2] Wang, C. & Daro, D (1998). *"Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse. Wang, C. & Daro, D (1997). *"Current trends in child abuse reporting and fatalities: The results of the 1996 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse. Wang, C. & Daro, D (1996). *"Current trends in child abuse reporting and fatalities: The results of the 1995 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse.

[3] Wang, C. & Daro, D (1998). *"Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse.

[4] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 1997: Reports from the States to the National Child Abuse and Neglect Data System.* Washington, DC: U.S. Government Printing Office, 1997

[5] Massachusetts Department of Social Services (DSS)(2000). *Child Maltreatment Statistics 1987-1999.* [composite report compiled for Massachusetts Citizens for Children]. (henceforth DSS, *Child Maltreatment Statistics 2000*).

[6] DiNatale and Hock Research (1998). "Public Opinion and the State of Children in Massachusetts in 1998." Boston, Massachusetts: Massachusetts Citizens for Children.

[7] The University of Massachusetts Poll (2000). "Public Opinion About Child Abuse in Massachusetts in 2000." Boston, Massachusetts: Massachusetts Citizens for Children.

[8] The Stride Rite Foundation (2000). "Strategies for Children": 14.

[9] U.S. Department of Commerce, Bureau of the Census, unpublished data.

[10] Massachusetts Department of Social Services (DSS) (1998). *1997 Child Maltreatment Statistic* . iv. (henceforth DSS, *Child Maltreatment Statistics 1997*.)

[11] FBI Uniform Crime Reporting Program (1999). *Uniform Crime Report.*

[12] Wang, C. & Harding, K (1999). *"Current trends in child abuse reporting and fatalities: results of the 1998 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse.

[13] DSS, *Child Maltreatment Statistics 1997.*

[14] Kilpatrick, J (November 1996). "From the Mouths of Victims: What Victimization Surveys tell us about Sexual Assaults and Sex Offenders." 15th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers. (henceforth "From the Mouths of Victims.").

[15] Felitti, J, Anda, R, Nordenberg, D, et. al. (1998). "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study."*American Journal of Preventive Medicine* 14 (4). (henceforth "The ACE Study.").

[16] DSS, *Child Maltreatment Statistics* 1997

[17] Finkelhor, D (1994). "Current Information on the Scope and Nature of Child Sexual Abuse." *The Future of Children.* 4(2). (henceforth " The Scope and Nature of Child Sexual Abuse.")

[18] Ibid, 57.

[19] Ibid.

[20] Ibid.

[21] National Center on Child Abuse Prevention and Research at Prevent Child Abuse America (2000). *Child Neglect.* Chicago, Il.

[22] Ibid.

[23] Ibid.

[24] American Academy of Pediatrics Committee on Child Abuse and Neglect (1993). *Pediatrics.* 92: 872-875.

---

[25] Duhaime, AC, Gennarelli, TA, Thibault, LE, Bruce, DA, Marguiles, SS, & Wiser, R (1987). *Journal of Neurosurgery*. 66:409-415.

[26] Dias MS, & Barthauer L (December 1999). "Western New York/Finger Lake Regional Shaken Baby Education Project." State University of New York at Buffalo and University of Rochester. (unpublished data). (henceforth "Western New York/Finger Lake Regional Shaken Baby Education Project.").

[27] Wang, C, & Daro, D (1998). *"Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty-state survey."* National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse.

[28] Finkelhor, D, and Jones, L (2001). "The Decline in Child Sexual Abuse Cases. *Juvenile Justice Bulletin*. Office of Juvenile Justice and Delinquency Prevention.

[29] Ibid.

[30] Beckett, K (1996). "Culture and politics of signification: The case of child sexual abuse." *Social Problems*. 43:57-75; Myers, JB, (1994). *The Backlash: Child Protection Under Fire.*; Thousand Oaks, CA: Sage Publications.

[31] Ibid.

[32] "The Scope and Nature of Child Sexual Abuse."

[33] "From the Mouths of Victims." (citing D. Finkelhor)

[34] Briere, JN, and Elliott, DM (Summer/Fall 1994). "Immediate and Long-Term Impacts of Child Sexual Abuse." *The Future of Children, Sexual Abuse of Children* 4(2): 59.

[35] Ibid, 56, (citing Barahal, R, Waterman, J, and Martin, H (1981). "The social-cognitive development of abused children." *Journal of Consulting and Clinical Psychology* 49:508-16; Oates, RK, Forest, D, & Peacock A (1985). "Self-esteem of abused children." *Child Abuse & Neglect* 9:159-63.

[36] Ibid, 60.

[37] Garbarino, J, Guttman, E, & Seeley, J (1987). *The Psychologically Battered Child.* San Francisco: Jossey-Boass Publishers.

[38] Meyers, M, & Bernier, J (1990). *Preventing Child Abuse: A Resource for Policymakers and Advocates.* Massachusetts Committee For Children and Youth: 17. (henceforth *Preventing Child Abuse*).

[39] Katz, M (1997). "Overcoming Childhood Adversities: Lessons Learned from Those Who Have "Beat the Odds." *Intervention in School and Clinic* 32:4 (205-210).

[40] Nash, MJ (February 3, 1997). "How a Child's Brain Develops." *Time Magazine*. 51.

[41] Perry, B, et al. (1995). "Childhood Trauma: The Neurobiology of Adaptation." *Infant Mental Health Journal* 16: 271. (henceforth "Childhood Trauma: The Neurobiology of Adaptation").

[42] "Childhood Trauma: The Neurobiology of Adaption."

[43] Ibid.

[44] van der Kolk, B, Crozier, JM, & Hopper, J, PhD. "Child Abuse in America: Prevalence, Costs, Consequences, and Intervention." Brookline, Massachusetts: The Trauma Center at HRI/Boston University School of Medicine. (henceforth "Child Abuse in America").

[45] Garner, DM, and Garfinkel PE, eds. (1985). *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia.* London: Guilford Press.

[46] "Child Abuse in America."

[47] *Healthy Child Care America* (January 1998) 3(1). (henceforth *Healthy Child Care America*).

[48] "Childhood Trauma: The Neurobiology of Adaption."

[49] Ibid.

[50] Ibid.

[51] *Healthy Child Care America.*

[52] Ibid.

[53] Perry, B (May 30, 1999). "Stress of Violence Tied to Changes in Children's Brains." *Boston Sunday Globe*.

[54] Brownlee, S. "The Biology of Soul Murder." *US News Online*: 8-12. (henceforth "The Biology of Soul Murder").

[55] *Healthy Child Care America.*

Endnotes

---

[56] Ibid.

[57] "Child Abuse in America."

[58] "Childhood Trauma: The Neurobiology of Adaptation."

[59] "Child Abuse in America."

[60] "Childhood Trauma: The Neurobiology of Adaptation" iv-v.

[61] Daro, D (1998). *Confronting Child Abuse*. London: The Free Press. 154.

[62] "The ACE Study."

[63] "Child Abuse in America." (citing McCord's study, 1983).

[64] Widom, CS (1992). "The Cycle of Violence." United States Department of Justice.

[65] *Preventing Child Abuse*.

[66] "Child Abuse in America" 10.

[67] "Child Abuse in America" 1-7, 10 (Table 2).

[68] "The Biology of Soul Murder."

[69] Katz, M (1997). "New Insights Into Childhood Risk and Adversities and Into the Lives of Those who Have Overcome Them." *On Playing a Poor Hand Well: Insights from the Lives of Those Who Have Overcome Childhood Risks and Adversities*. New York: W.W. Norton and Company.

[70] Ibid.

[71] Carlson, BE (1984). "Children's observations of Interpersonal Violence." *Battered Women and Their Families*. AR Roberts, ed. New York: Springer Publishing.

[72] Strauss, MA (1992). "Children as witnesses to marital violence: A risk factor for lifelong problems among a nationally representative sample of American men and women." *Children and Violence: Report of the Twenty-third Ross Round on Critical Approaches to Common Pediatric Problems*. DF Schwartz, ed. Columbus, OH: Ross Laboratories.

[73] Office of the Commissioner of Probation (1997). "Children Affected by Domestic Violence Report."

[74] Edelson, JL (February 1999). "The Overlap Between Child Maltreatment and Women Battering." *Violence Against Women* 5:134-54.

[75] *Physical violence in American families*.

[76] "Children Affected by Domestic Violence." (citing McKibben, DeVos and Newberger, 1987).

[77] National Center on Child Abuse Prevention Research at Prevent Child Abuse America (September, 2000). *"Domestic Violence and Child Abuse and Neglect."* Chicago, IL.

[78] Ibid.

[79] Gazmararian, JA, Lazorik, S, Spitz, AM, Ballard, TJ, Saltzman, LE, and Marks, JS (June 26, 1999). *Prevalence of Violence Against Pregnant Women*. JAMA 275 (24): 1915-1920.

[80] Campbell, J (August 1995). "Addressing Battering During Pregnancy: Reducing Low Birth Weight and Ogoing Abuse." *Seminars in Perinatology* 19 (4): 301-306.

[81] Strauss, MA & Gelles, RJ (1990). *Physical violence in American families*. New Brunswick, NJ: Transaction Publishers. (henceforth *Physical violence in American families*).

[82] Ibid.

[83] Margolin, G (1998). "Effects of Domestic Violence on Children." *Violence Against Children in the Family and the Community*. Washington DC: American Psychological Association. 57-102. (citing McCloskey, Figueredo, and Doss (1995).

[84] U.S. Advisory Board on Child Abuse and Neglect (1995). "A Nation's Shame: Fatal Child Abuse and Neglect in the United Sates." Washington, DC: US Department of Health and Human Services. (henceforth "A Nation's Shame: Fatal Child Abuse and Neglect in the United States").

[85] Ibid.

[86] Perry, BD (July 2000). "The Neuroarcheology of Childhood Maltreatment: The Neurodevelopmental Costs of Adverse Childhood Events." (citing Kilpatrick and Williams, 1998).

---

[87] Whitney, P. and Davis, L (May 1999). "Child Abuse and Domestic Violence in Massachusetts: Can Practice Be Integrated in a Public Child Welfare Setting?" *Child Maltreatment* 4(2): 158-166. (henceforth "Child Abuse and Domestic Violence in Massachusetts.")

[88] Ibid.

[89] Heller, J, Gyurina, CH, and M Rosenbaum (1997). *Survey of Department of Social Services Social Workers, Supervisors, and Area Program Managers on the Use of Domestic Violence Specialist, Domestic Violence Protocols, and Understanding of Domestic Violence in DSS Caseloads.* Boston, Massachusetts: Department of Social Services.

[90] "Child Abuse and Domestic Violence in Massachusetts."

[91] "Children Affected by Domestic Violence."

[92] National Center on Addiction and Substance Abuse at Columbia University (January 1999). *No Safe Haven: Children of Substance-Abusing Parents.* New York, NY. (henceforth *No Safe Haven.*)

[93] Ibid.

[94] Ibid.

[95] The National Center on Addiction and Substance Abuse at Columbia University (1996). *Substance abuse and the American Woman.* New York, NY.

[96] Miller, MM. & Potter-Efron, RT (1990). *Aggression and violence associated with substance abuse.* In Potter-Efron, RT. & Potter-Efron, PS, eds. *Aggression, family violence and chemical dependency.* New York: The Haworth Press.

[97] The National Center on Addiction and Substance Abuse at Columbia University (1998). *Behind Bars: Substance abuse and America's prison population.* New York, NY.

[98] Ibid.

[99] Miller, BA, Maguin E, & Downs, W (1997). *Alcohol, drugs, and violence in children's lives.* In Galanter, M, ed. *Recent developments in alcoholism: Alcohol and violence.* New York: Plenum Press; Thompson, M. & Kingree, JB (1998). "The frequency and impact of violent trauma among pregnant substance abusers." *Addictive Behaviors* 23(2): 257-262.

[100] Miller, BA, & Downs, WR (1993). "The impact of family violence on the use of alcohol by women." *Alcohol Health and Research World* 17(2):137-143.

[101] Browne, A. & Finkelhor, D (1986). "Impact of child sexual abuse: A review of the research." *Psychological Bulletin* 99(1): 66-77.

[102] *No Safe Haven.*

[103] National Center on Addiction and Substance Abuse at Columbia University (January 2001). *Shoveling Up: The Impact of Substance Abuse on State Budgets.* New York, NY.

[104] The Better Homes Fund (1999). *Homeless Children: America's New Outcasts.* Newton, Massachusetts. (henceforth *Homeless Children.*)

[105] Commonwealth of Massachusetts, Executive Office for Administration and Finance (December, 1999). *Homelessness in Massachusetts. Who are the Homeless in Massachusetts?* Boston, Massachusetts.

[106] Massachusetts Citizens for Children (1986). *No Place Like Home: A Report on the Tragedy of Homeless Children and Their Families in Massachusetts.* Boston, Massachusetts.

[107] *Homeless Children.*

[108] Ibid.

[109] Ibid.

[110] Ibid.

[111] Ibid.

[112] "Child Abuse in America."

[113] *Homeless Children.* Quoting unpublished data from the Worcester Family Research Project. Newton, Massachusetts: The Better Homes Fund.

[114] Petit, M. and Curtis, P (1997). *Child Abuse and Neglect: A Look at the States.* Washington, DC: Child Welfare League of America Press. 72-75.

[115] Ibid.

---

[116] Bassuk, E., Weinreb, L., Buckner, J., Browne, A., Salomon, A. and Bassuk, S (1996). "The characteristics and needs of sheltered homeless and low-income housed mothers." *Journal of the American Medical Association* 276(8): 640-646. (henceforth "The characteristics and needs of sheltered homeless.")

[117] Bassuk, E., Buckner, J., Weinreb, L., Browne, A., Bassuk, S., Dawson, R. and Perloff, J (1997). "Homelessness in female-headed families: children and adult risk and protective factors." *American Journal of Public Health* 87(2): 241-248.

[118] "The characteristics and needs of sheltered homeless and low-income housed mothers."

[119] Ibid.

[120] Ibid.

[121] Bassuk, E., Buckner, J., Perloff, J. and Bassuk, S. (1998). "Prevalence of mental health and substance use disorders among homeless and low-income housed mothers." *The American Journal of Psychiatry* 155(11):1561-1564.

[122] Bassuk, E., Weinreb, L., Dawson, R. and Buckner, J (1997). "Determinants of behavior in homeless and low-income housed preschool children." *Pediatrics* 100(1): 92-100.

[123] Weinreb, L., Goldberg, R., Bassuk, E., and Perloff, J (1998). "Determinants of health and service use patterns in homeless and low-income housed children." *Pediatrics* 102(3): 554-562.

[124] Buckner, J. and Bassuk, E. (1997). "Mental disorders and service utilization among youths from homeless and low-income housed families." *Journal of the American Academy of Child and Adolescent Psychiatry* 36(7): 890-900.

[125] *Homeless Children.*

[126] Ibid.

[127] *Homeless Children.* Quoting unpublished data from the Worcester Family Research Project. Newton, Massachusetts: The Better Homes Fund.

[128] M.G.L. Chapter 119, 51A.

[129] DSS, *Child Maltreatment Statistics 2000.*

[130] This represents children who may have been reported more than once for the same incident of abuse or neglect or children who were reported more than once for different types of abuse.

[131] M.G.L. Chapter 119, 51B.

[132] Epstein, H (Winter 1999). "Issue Brief: A Child Advocate's Guide to State Child Protective Services Reform." *National Association of Child Advocates*: 3. (henceforth "Issue Brief: A Child Advocate's Guide to State Child Protective Services Reform.")

[133] Waldfogel, J (January/February 2000). "Reforming Child Protective Services." *Child Welfare* Volume LXXIX (1): 44. (henceforth "Reforming Child Protective Services.")

[134] "Issue Brief: A Child Advocate's Guide to State and Child Protective Services Reform" 2.

[135] "Child Abuse and Neglect - Protecting Massachusetts Children." *Massachusetts KIDS COUNT Report*, 1998.

[136] "Issue Brief: A Child Advocate's Guide to State Child Protective Services Reform." 2.

[137] Ibid.

[138] "Reforming Child Protective Services" 47.

[139] Ibid. 44.

[140] "Issue Brief: A Child Advocate's Guide to State Child Protective Services Reform" 3.

[141] Ibid.

[142] Ibid.

[143] Morton, T (December 1999). "Embracing the Challenge of Child Safety." *Child Welfare Institute.*

[144] Institute of Applied Research (January 1998). *Missouri Child Protection Services Family Assessment and Response Demonstration: Impact Evaluation*: 7. (henceforth *Missouri Impact Evaluation.*)

[145] Ibid.

[146] Ibid.

[147] Holden, W. and Morton, T (February 1999). "Designing a Comprehensive Approach to Child Safety." *National Resource Center on Child Maltreatment*: 5.

[148] Ibid.

BEST COPY AVAILABLE

---

[149] Ibid.

[150] Ibid.

[151] Special Committee on Family Support and the Child Welfare System (November 1992). *From Crisis to Opportunity: Recommendation for Promoting Child and Family Well-Being in Massachusetts*: 16. (henceforth *From Crisis to Opportunity.*)

[152] Vermont District of Social Services (2000). "Visitation and/or Contact Protocols." O.U.R. House of Central Vermont, Inc. Barre, Vermont.

[153] California Attorney General's Office (July, 1994). "Child victim witness investigative pilot projects: Research and evaluation final report." Sacramento, California.

[154] Massachusetts Department of Social Services (DSS). *Task Force on Multidisciplinary Assessment: Final Report, 1996.* (henceforth DSS, *Final Report 1996.*)

[155] Ibid.

[156] Ibid.

[157] Ibid.

[158] Ibid.

[159] Florida Department of Public Health: Children's Medical Services. *CPT Statistical Reports, 1997-1999.* (henceforth *Florida CPT Statistical Reports 1997-1999.*)

[160] Ibid.

[161] Ibid.

[162] Ibid.

[163] Ibid.

[164] Ibid.

[165] DSS, *Final Report 1996.*

[166] Cross, T. and Spath, R (1998). *Evaluation of Massachusetts' Sexual Abuse Intervention Network.* Unpublished Manuscript, Brandeis University, Waltham, MA. (henceforth *Evaluation of Massachusetts' Sexual Abuse Intervention Network.*)

[167] Ibid.

[168] Ibid.

[169] Ibid.

[170] Ibid. (citing Sheppard and Zangrillo (1996)).

[171] Ibid.

[172] Ibid.

[173] Ibid.

[174] The Massachusetts Chapter of the National Network of Children's Advocacy Centers and The Massachusetts Department of Social Services (May 1997).

[175] DSS, *Final Report 1996.*

[176] Ibid.

[177] Ibid.

[178] Ibid.

[179] Field study conducted by Massachusetts Citizens for Children (Summer 2000).

[180] Personal Communication with Dr. Edward Bailey, May 2000.

[181] (November 27, 2000). "Congress Weighs Boost in Funds for Children's Hospitals." *Boston Globe.*

[182] Ibid.

[183] Ibid.

[184] Massachusetts Department of Social Services (DSS) (1996). *Request for Proposal (RFP) for DSS Area Multidisciplinary Assessment Teams.* [RFP presented to the Massachusetts Department of Social Services 1998];

DSS. Task Force on Multidisciplinary Assessment: Final Report. (henceforth *Request for Proposal(RFP) for DSS Area Multidisciplinary Assessment Teams.*).

[185] DSS. *Final Report 1996.*

[186] *Request for Proposal (RFP) for DSS Area Multidisciplinary Assessment Teams.*

[187] DSS. *Child Maltreatment Statistics* 1997.

[188] Massachusetts Department of Social Services (DSS) (1999). *Multidisciplinary Assessment Teams Evaluation Phase II: Team Member Survey.*

[189] Ibid.

[190] Ibid.

[191] Ibid.

[192] The Commonwealth of Massachusetts House Post Audit and Oversight Bureau (1998). *Preliminary Report.* Boston, Massachusetts: Department of Social Services; The Commonwealth of Massachusetts (1992). *Report of the Senate Committee on Post Audit and Oversight: Social Worker Caseload and Resource Availability at the Department of Social Services.* Boston, Massachusetts.

[193] Massachusetts Governor's Commission on Foster Care (1993). *Final Report.* Boston, Massachusetts. (henceforth Governor's Commission on Foster Care).

[194] Michaels, N, and Carey, J (May 16, 2000). "Memorandum re: Family Based Services and Multidisciplinary Assessment Teams." Massachusetts Department of Social Services.

[195] *Florida CPT Statistical Reports 1997-1999.*

[196] Keaney, W (1994). "Rescuing Families Instead of Children: Building Family Support into Protective Services." Ann Arbor, Michigan: University of Michigan Press.

[197] Governor's Commission on Foster Care.

[198] Child Welfare League of America (1996). *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families.* Washington, DC. 137.

[199] Governor's Commission on Foster Care.

[200] The Commonwealth of Massachusetts Board of Registration of Social Workers Rules and Regulations: CMR 258-12:00.

[201] Casey Family Program, Annie E. Casey Foundation (March, 2000). "Facts About Foster Care: National Foster Care Awareness Project." (henceforth "Facts About Foster Care.").

[202] Ibid.

[203] U.S. Department of Health and Human Services, Administration on Children, Youth and Families (1997). *Child Maltreatment 1999: Reports from the States to the National Child Abuse and Neglect Data System.* Washington, DC: U.S. Government Printing Office.

[204] Casey Family Programs (2001). *Lighting the Way: Attracting and Supporting Foster Families.* Seattle, Washington.

[205] Massachusetts Department of Social Services (1998). *Demographic Report on Consumer Populations.* (henceforth *Demographic Report on Consumer Populations.*).

[206] Petit, MR, Curtis, PA (1997). *Child Abuse and Neglect: A Look at the States. 1997 CWLA Stat Book.* Washington, DC: Child Welfare League of America. 7.

[207] Prentky, RA, Knight, RA, Sims-Knight, JE, Straus, H, Rokous, F, and Circe, D (1989). "Developmental Antecedents of Sexual Aggression." *Development and Psychopathology* 1:153-169.

[208] Massachusetts Department of Social Services (1998). *Demographic Report on Consumer Populations.*

[209] "Facts About Foster Care."

[210] Ibid.

[211] Casey Family Programs (2001). *Lighting the Way: Attracting and Supporting Foster Families.* Seattle, Washington.

[212] National Adoption Center (2001). "Faces of Adoption: America's Waiting Children."

[213] US Department of Health and Human Services, Administration on Children, Youth and Families, Log. No. ACYF-PI-CB-98-01.

---

[214] Congressional Record-House. pp. H11148-9. September 25, 1996.

[215] Based on informational interviews conducted with several members of the Professional Advisory Council during the summer of 2000 by Massachusetts Citizens for Children.

[216] The North Carolina Fatality Task Force was able to conclude from the data that the leading cause of death to children was from bicycle and motor vehicle accidents, and their finding led to the passage of legislation requiring minors under the age of 19 to wear bicycle helmets.

[217] Report of the Gender Bias Study of the Supreme Judicial Court of the Commonwealth of Massachusetts (1989): 59.

[218] The Wellesley Center for Women (Fall/Winter 2000). "Research Report." 22(1): 6.

[219] Care and Protection of Isaac, (1995) 419 Mass. 602, 646 N.E. 2d 1034.

[220] Care and Protection of Jeremy, (1995) 419 Mass 616, 646 N.E. 2d 1029.

[221] Beinecke, RH (1999). "Children and Youth in Massachusetts Residential Treatment Centers: Who They are and Recommendations for Improving the Quality of Care: A Survey of Massachusetts Children's Residential Treatment Providers." Suffolk University Department of Public Management for The Children's League of Massachusetts, Inc." Boston.

[222] Knox, R. and Dember, A (June 4, 2000). "Trapped in mental ward." *Boston Globe*.

[223] Ibid.

[224] Bronfenbrenner, U (1979). "The ecology of human development." Cambridge, MA: Harvard University Press; Cicchetti, D. and Lynch, M (1993). "Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development." *Psychiatry* 56: 96-118; Harvey, M (1996). "An ecological view of psychological trauma and trauma recovery." *Journal of Traumatic Stress* 9:3-23 ; Henngeler, SW, et al. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. NY: Guildford Press.

[225] Saxe,G (April 2000). A Lecture on Treating Traumatized Children. Waltham, Massachusetts, Chairman, Department of Child and Adolescent Psychiatry, Boston University School of Medicine.

[226] Ibid.

[227] Bourduin, CM, Mann, BJ, Cone, LT, Henggeler, SW, Fucci, BR, Blaske, DM, and Williams, RA (1995). "Multisystemic treatment of serious juvenile offenders: Long term prevention of criminality and violence." *Journal of Consulting and Clinical Psychology* 63: 569-578.

[228] Brunk, M, Henggeler, S, and Whelan, J (1987). "Comparison of multisystemic therapy and parent training intervention in the treatment of child abuse and neglect." *Journal of Consulting and Clinical Psychology* 55: 171-178.

[229] Saxe, G (April 2000). A Lecture on Treating Traumatized Children, April, 2000. Waltham Massachusetts, Chairman, Department of Child and Adolescent Psychiatry, Boston University School of Medicine.

[230] Ibid.

[231] Carlson, EB, et al. (1997). "A Conceptual Framework for the Long-Term Psychological Effects of Traumatic Child Abuse." *Child Maltreatment*: 272, 277.

[232] See Mark Katz (March 31, 2000). "Overcoming Childhood Adversities: Lessons Learned from Those Who Beat the Odds." Remarks at Massachusetts Committee on Children and Youth Symposium. See also, Katz, M (1997). *On Playing a Poor Hand Well: Insights from the Lives of those Who Have Overcome Childhood Risks and Adversities*. New York: W.W. Norton & Company, 5-9.

[233] Pfefferbaum, B (1997). "Posttraumatic Stress Disorder in Children: A Review of the Past 10 Years." 36 *American Academy of Child and Adolescent Psychiatry* 1503, 1509.

[234] See Mark Katz (March 31, 2000). "Overcoming Childhood Adversities: Lessons Learned from Those Who Beat the Odds." Remarks at Massachusetts Committee on Children and Youth Symposium. See also, M. Katz (1997). *On Playing a Poor Hand Well: Insights from the Lives of those Who Have Overcome Childhood Risks and Adversities*. New York: W.W. Norton & Company.

[235] Cole, SF, and Gadd, MG (2000). "Uncovering the Roots of School Violence." *New England Law Review* 34: 601-614, 609.

[236] van der Kolk, B (January 16, 2001). Remarks at conference. "Helping Traumatized Children Learn." Sponsored by Lesley University Center for Special Education, the Massachusetts Advocacy Center, and the Task Force on Children Affected by Domestic Violence.

[237] Craig, S (September, 1992). "The Educational Needs of Children Living with Violence." *Phi Delta Kappan*: 67-71, 68.

---

[238] Boykin-McCarthy, J. *Emancipatory Learning: A Study of Teachers' Perspective Shifts Regarding Children of Battered Women.* (Doctoral Dissertation, The Fielding Institute).

[239] van der Kolk, B (1994). "The Body Keeps Score: Memory and the Evolving Psychobiology of Posttraumatic Stress." (Available on-line: www.trauma-pages.com/vanderk4.htm).

[240] van der Kolk, B. Remarks at conference, "Helping Traumatized Children Learn." *See also*, Fish-Murray, C, Koby, E. and van der Kolk, B (1987). *Psychological Trauma.* van der Kolk, B, ed. Washington, DC: American Psychiatric Press, Inc. 89-110, 105.

[241] Ibid. Programs such as "model mugging" and "urban improv" are being studied for their ameliorative potential for addressing trauma symptoms.

[242] Perry, B. et al. (2000). "Positive Developmental Effects of a Brief Music and Movement Program at a Public School: A Pilot Project of the Neighborhood Arts Enrichment Program." (Available online: http://www.bcm.tmc.edu/cta/neigh_arts.htm).

[243] Boykin-McCarthy, J (January 16, 2001). Remarks at "Helping Traumatized Children Learn."

[244] van der Kolk, B (January 16, 2001). Remarks at "Helping Traumatized Children Learn."

[245] Large numbers of traumatized children are diagnosed as having learning disabilities and ADHD, and the co-morbidity between the two is high. See e.g., Biederman, J, et al. (1991). "Comorbidity of Attention Deficit Hyperactivity Disorder with Conduct, Depressive, Anxiety, and Other Disorders." *American Journal of Psychiatry* 148: 564-7; Famularo R, Kinscherff, R, Fenton, T (1992). "Psychiatric Diagnoses of Maltreated Children: Preliminary Findings." *Journal of the American Academy of Child and Adolescent Psychiatry* 31:863-867.

[246] Allen, ML, Brown, P, and Findlay, B (1992). "Helping Children by Strengthening Families: A Look at Family Support Programs." *Children's Defense Fund.* (henceforth "Helping Children by Strengthening Families.")

[247] Ibid.

[248] Ibid.

[249] Ibid.

[250] Urban Institute (1997). *National Survey of America's Families.* Washington, DC.

[251] "Helping Children by Strengthening Families."

[252] Family Preservation and Support Act of 1993.

[253] Massachusetts Special Committee on Family Support and the Child Welfare System (1992). *Executive Summary, From Crisis to Opportunity: Recommendations for Promoting Child and Family Well Being in Massachusetts.* Boston, MA.

[254] Bing, S (1999). "Trust the Village to Raise a Child: Creation of a Strength-Based Family Support System." Massachusetts Special Committee on Family Support and the Child Welfare System. Boston, MA.

[255] "Helping Children by Strengthening Families."

[256] Edna McConnell Clark Foundation (Fall 1999). "Individualized Courses of Action: Enhancing the Way We Work." *Community Partnerships for Protecting Children* 4 (1).

[257] Welty, K (Spring 1997). "Family Group Decision Making: Implications for Permanency Planning." *North American Council on Adoptable Children.*

[258] Wilder Research Center (1998). "Family Support Project Evaluation Final Report." Minnesota.

[259] *Missouri Impact Evaluation.*

[260] Schorr, L (1998). "Community Connections: Working together to support Massachusetts Families."

[261] Ibid.

[262] Massachusetts Department of Education, (2001) Early Learning Services.

[263] Sedlak, A, Broadhurst, D (1996). *Third National Incidence Study of Child Abuse and Neglect (NIS-3):Executive Summary.* Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families.

[264] National Center on Child Abuse Prevention Research at Prevent Child Abuse America (1999). "Answers to Frequently Asked Questions About Healthy Families America." Chicago, IL.

[265] Olds, D, Eckenrode, J, Henderson, C Jr., et al. (1997). "Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial." *Journal of the American Medical Association* 278: 637-43.

---

[266] Massachusetts Special Committee on Family Support and the Child Welfare System (1992). *Executive Summary. From Crisis to Opportunity: Recommendations for Promoting Child and Family Well Being in Massachusetts* Boston, MA.

[267] Behavior Associates (1976). "Evaluation of Parents Anonymous." Tucson, Arizona.

[268] U.S. Department of Health, Education and Welfare, National Center for Health Services Research (1977). "Evaluation of Child Abuse and Neglect Demonstration Projects 1974-1977": 84-89.

[269] Bavolek, S (November 2000). "The Nurturing Parenting Programs." *Juvenile Justice Bulletin.* Washington, DC: Office of Juvenile Justice Delinquency Prevention.

[270] "Western New York/Finger Lake Regional Shaken Baby Education Project."

[271] Vermont Partnership for an Abuse Free State (May 2000). *"The 10 Best things Vermonters Are Doing to Prevent and Combat Child Sexual Abuses: A Guide to Making a Difference – for Parents, Community Members, and Professionals."* Montpelier, VT.

[272] Nemerofsky, A. Carran, D., Rosenberg, L (1994). "Age Variation in Performance Among Preschool Children in a Sexual Abuse Prevention Program." *Journal of Child Sexual Abuse* 3(1).

[273] Citizens for Juvenile Justice (January 2000). "Issue Briefing: DSS Gateway to Juvenile Crime." Boston. (henceforth " *DSS Gateway to Juvenile Crime*".)

[274] Ibid.

[275] *Preventing Child Abuse*

[276] "Child Abuse in America."

[277] *"DSS Gateway to Juvenile Crime"*

[278] Ibid.

[279] Ibid.

[280] Ibid.

[281] Jasinsky, J. and Siegel, W L. "Childhood Physical and Sexual Abuse as Risk Factors for Heavy Drinking Among African American Women: A Prospective Study." *Child Abuse and Neglect* 24 (8): 1061- 1062.

[282] DeParle, J (November 28, 1999). "Early Sex Abuse Hinders Many Women on Welfare." *New York Times* (henceforth "Early Sex Abuse Hinders Many Women on Welfare.")

[283] Ibid. 2.

[284] Ibid.

[285] "Western New York/Finger Lake Regional Shaken Baby Education Project."

[286] "Child Abuse in America."

[287] Ibid. (citing the National Committee for the Prevention of Child Abuse, 1994).

[288] Ibid.

[289] Ibid.

[290] Ibid. (citing the National Institute of Justice, 1996).

[291] National Center on Child Abuse Prevention Research at Prevent Child Abuse America. Chicago, IL.

[292] Remarks upon signing the Maternal and Child Health and Mental Retardation Planning Bill into law, October 24, 1963, *Public Papers of the Presidents*: 1963, p. 811.

Appendix A

The Summit Initiative on Child Protection and Family Support

Over the past decade, there have been numerous declarations by child advocates, child welfare providers and families themselves that child abuse and neglect in the U.S. represents a national emergency. Despite dramatic calls for reform, sensational media coverage of high profile cases, and occasional law suits, child protection systems in the states have not met the standards or expectations of most citizens.

In 1999, Massachusetts Citizens for Children made a commitment to build a broad and deep consensus for reform. That spring, it brought together fifty key child welfare policy leaders from Massachusetts and a dozen experts from across the nation to address the crisis in child protection and the need for family support and prevention strategies.

The two-day "Summit on Child Protection and Family Support" and subsequent post-Summit feedback supported a broader effort to bring about systemic changes. Four key goals were approved:

- To establish a shared baseline of information and data on current research and practice;
- To develop a proposed reform agenda among policy makers, child and family advocates, and providers;
- To educate opinion leaders, the general public, and media about that agenda;
- To mobilize citizen and legislative action to fund and implement reform.

To accomplish these goals, five Summit Working Groups were convened and met regularly over the six-month period from January through June, 2000. In April, May and June, MCC convened three daylong Symposia to discuss the newest brain research and its implications for children traumatized by abuse or family violence. Input from a broad range of mental health, child protection and school professionals resulted in numerous recommendations around policy, practice and prevention. Throughout this period, numerous other national and state experts in areas related to child protection and family support were are consulted.

Overall, two hundred child and family policymakers and advocates were involved in the Summit Initiative. They assessed the workings of the current system, explored promising models from other states, and debated options for change.

A description of the Work Groups and the scope of their work follows:

Work Group on Dual Track

Premise:

The current child protection system does not allow for differential responses to reports of serious and less serious reports of abuse and neglect. Though serious cases are screened in and investigated, the majority of reports (70% or more) are screened out with no services offered. Significant resources are expended in this process, while few or no benefits accrue to the families and children whose cases are screened out. Massachusetts should explore the dual track systems currently operating in over 10 states and determine if adopting such a strategy would result in a more efficient use of resources and better outcomes for children and families.

Scope of Work:

- Review Massachusetts' uniform approach to screening, assessing, investigating, and servicing reports/cases of abuse and neglect.
- Compile data regarding costs associated with screening out cases that are not deemed to require state agency involvement.
- Compile data, including cost data, outcome measures, related to dual track systems in other states.
- Identify child protection system improvements in dual track states.
- Explore identified barriers and challenges posed by dual track systems.
- Identify implication of dual track systems on current mandated reporting laws.

Work Group on Multidisciplinary Assessment

Premise:

Approximately 30% of children reported to the state child protection system have experienced serious abuse or neglect. These children require timely and comprehensive clinical assessments to determine their status, i.e. medical, psychosocial, legal, etc., and to develop an effective plan for treatment and intervention. These assessments can best be provided through permanent, community-based multidisciplinary child protection teams that operate under a statewide system grounded in uniform standards of practice and accountability.

Scope of Work:

- Document the current composition, location, referral mechanisms and overall functions of multidisciplinary teams in Massachusetts, i.e. Child Advocacy Centers (CACs), Sexual Assault Intervention Teams (SAIN teams), Multidisciplinary Assessment Teams (MDATs), hospital-based Child Protection Teams (CPTs).
- Document extent and sources of funding for the above.
- Compile and review data on multidisciplinary assessment teams in other states, e.g. types of cases referred; recidivism rates, prosecution rates, child fatality rates among teamed cases; satisfaction rates among mandatory reporters and families; etc.
- Examine legislation that authorizes the functioning and funding of teams, and the roles of state and community partners.

- Explore political and other elements that have contributed to the establishment and maintenance of effective team systems across the country.

Work Group on Family & Community Supports

Premise:

Approximately 70 percent of child abuse and neglect reports received by the child protection agency do not warrant court or law enforcement involvement. Children and families involved in these reports are generally screened out and away from the system without being offered any services or supports. Without an opportunity to have their needs assessed and addressed, many may experience further difficulty that could result in future reports. These cases could better be handled through a non-adversarial, community-based response system grounded in family support principles and practice.

Currently, Massachusetts has the beginnings of such a response system, however it is fragmented and lacks coordination. This system could be organized to serve both children and families reported to and screened away from the state agency, and families at-large who voluntarily seek a range of community-based supports. A coordinated, statewide system of family supports and services would promote strong families and prevent child abuse and neglect.

Scope of Work:

- Document the number of reports to DSS that are screened-out and unsupported, and the range of services provided/offered to this population.
- Document services provided to families and children involved in substantiated cases of abuse and neglect, including services provided through mental health managed care.
- Identify Massachusetts data from the Urban Institute's National Survey of America's Families and from other sources that document the need for family supports.
- Explore how a statewide, coordinated system would impact current family support/prevention partnerships and programs involving the Department of Social Services, the Children's Trust Fund, the Department of Public Health, the Department of Education, and local schools.
- Explore models of community partnerships in other states, including mechanisms available to children and families that can both assess and address their identified needs.
- Document current Federal, State and local funding for child and family services and community supports.

Work Group on Treatment and Intervention

Premise:

Most current clinical practice involving child victims of serious abuse and neglect does not reflect the latest research and data on the effects of trauma on the developing brain. Implications of this research must be more fully understood by policymakers and practitioners so child victims can benefit from effective state-of-the-art treatment and interventions that address both immediate safety risk and long-term developmental risk.

Scope of Work:

- Compile a comprehensive library of the most current data about the effects of child abuse/neglect trauma on children's brain development, e.g. articles, studies, etc.
- Compile research data concerning the links between poor scholastic performance, low MCAS test scores, behavioral problems, etc. and exposure to family violence and/or abuse.
- Convene a series of symposia for Summit work group members and other policymakers and practitioners aimed at imparting the new data, documenting its impact on children's medical, psychological, behavioral and educational status, and distilling policy and programmatic recommendations.
- Document the current network of treatment services for Massachusetts' abused and neglected children, and its associated costs.
- Identify gaps in the provision of treatment services, including types of specialized services, availability of trained practitioners, geographic limitations, etc.
- Document the costs associated with not developing and providing effective treatment and interventions for abused/neglected children in Massachusetts.

Work Group on Workforce/Workload

Premise:

An effective and efficient child protection system requires a competent, adequately staffed and professionally trained work force, and a manageable workload that supports quality casework.

Scope of Work:

- Review Massachusetts data regarding number of workers in workforce, turnover rate, percentage of workers/supervisors with advanced degrees, in-service training, etc.
- Compile budgetary information about current level of support.
- Compile information about current recruitment practices, including roles of schools of social work, NASW, etc.
- Identify barriers to maintaining a competent workforce.
- Compile and examine data on innovative workforce/workload practices from other states.
- Review related legislation supporting improved workforce/workload practices in other states.
- Explore how identified best practices can be incorporated into the Massachusetts child protection system.

Appendix B

Summit Initiative Participants 1999-2001

**Designates participation in Summit Work Groups*

Judy Abrahams	Area Director, Massachusetts Department of Social Services (DSS) – Framingham Area
Bettye Ackerman, Esq.	Staff Attorney, South Middlesex Legal Services
Jennifer Agosti	Director, Management, Planning and Analysis, DSS
Robin Anapol	SAIN Coordinator, Office of Plymouth County District Attorney
Jeannette Atkinson*	Executive Director, Parents Helping Parents
Suzin Bartley	Executive Director, Children's Trust Fund
Jetta Bernier*	Executive Director, Massachusetts Citizens for Children
Stephen R. Bing, Esq.	Special Committee on Family Support and the Child Welfare System
Holly Bishop, LICSW	Mental Health Consultant, Office of Suffolk County District Attorney
Maurice J. Boisvert	Executive Director, Youth Opportunities Upheld (YOU), Worcester
Jacquelynne Bowman, Esq.*	Associate Director, Greater Boston Legal Services
Carol Brill, MSW	Executive Director, National Association of Social Workers (NASW) – Massachusetts Chapter
Carolyn Burns, MSW	Executive Director, Berkshire Center for Families and Children
Virginia Burns, MSW	Founding Chairperson, Special Committee on Family Support and the Child Welfare System
Lori Button	Director of Child & Adolescent Services, Massachusetts Behavioral Health Partnership
Gary Calhoun*	Director of Training, DSS
Ann Capoccia	Child and Adolescent Services, Massachusetts Department of Public Health (DPH)
Jan Carey*	Behavioral Health/CAPTA Manager, DSS
Bonny Carroll*	Somerville Mayor's Office of Human Services, Somerville Community Services Center
Anne Cavanaugh	Children's Charter, Inc.
Barbara Ceve	Program Manager, DSS – Pittsfield Area
Virginia Chan	DSS – Dimock Street Area
Megan Christopher	South Middlesex Legal Services
Helen Chwaliszewski	Social Worker IV, DSS – Lynn Area
Sandra Clark	Deputy Director, Victim Compensation and Assistance Division, Office of the Attorney General
Bonnie Clarke	Program Manager, DSS – Coastal Area
Martha Coakley, Esq.*	District Attorney, Middlesex County
Susan Cole*	Director, Children's Law Support Project, Massachusetts Advocacy Center
Joseph Collins	Area Director, DSS – Greenfield Area
Carol Costanzo	Program Manager, DSS – Park Street Area

Ted Cross, PhD*	Professor, Department of Psychology, Brandeis University
Christina Crowe	Director or Educational, Clinical and Community Programs, Judge Baker Children's Center
Brian Cummings	Director, Community Connections, DSS
Julie Dale, Esq.	Assistant District Attorney, Middlesex County
Lonna Davis, MSW	Clinical Supervisor, Domestic Violence & Family Support Unit, DSS
Susan Dillard, Esq.*	Co-Director, Children and Family Law Program, Committee for Public Counsel Law Services
Lou DiNatale	Director, Center for State & Local Policy, McCormack Institute, University of Massachusetts
Kate Dolan, LICSW	Child Clinician, Berkshire Children's Advocacy Center
Beryl Domingo*	Director of Field Support, DSS
Eleanor Dowd	Regional Director, DSS – Metro Area
Colette Doyle	Clinical Manager, DSS – Northeast Regional Area
Pat Dubus	Director of Programs and Evaluation, The Better Homes Fund
Mary Beth Dwyer	Flaschner Judicial Institute
Dorothy Eagan, MSW	Edna Gill Advocacy Fellow, NASW – Massachusetts Chapter
James Early	Administrator of Special Education Services, Watertown Public Schools
Peggy Enright	Center for Children and Families, Education Development Center, Inc.
Susan Farb	Learning Support Division, Massachusetts Department of Education
Margaret S. Fearey	Associate Justice, Juvenile Court, Middlesex
Donna G. Feinberg, LICSW	Norfolk Probate Court
Deborah Ferreri	Massachusetts Citizens for Children
Janet E. Fine*	Chief, Victim Witness Assistance Program, Office of Suffolk Count District Attorney
Sandra Fitzsimmons	Area Director, DSS – Fall River Area
Alcine Fleurimor	Healthy Baby / Healthy Child Program
Sally Fogerty	Acting Commissioner, Bureau of Family and Community Health, DPH
Lauren Frey	Director, Massachusetts Families for Kids, Children's Services of Roxbury
Brenda Gadson	Executive Director, Roxbury Multi-Service Center, Inc.
Janine Gannon	Director, Child Witness to Domestic Violence Project, Office of the Attorney General
Jack Gately	Executive Director, Citizens for Juvenile Justice
Jacqueline Gervais	Area Director, DSS – Cape Ann Area
Lynn Girton, Esq.*	Chief Counsel, Volunteer Lawyers Project
Mary Gleaves, MSW	Family Service of Greater Boston
Susan Goldfarb	Office of Suffolk County District Attorney
Richard A. Goodman, PhD, MEd	Certified Psychoanalyst
Martha P. Grace	Chief Justice, Trial Court of the Commonwealth, Juvenile Court
Wanda Grant-Knight	Boston Medical Center
Michelle Griffin	Children's Law Center of Massachusetts
Linda Grillo	Parent Representative (Hingham), Adoptive Families Together Initiative
Betsy McAlister Groves, LICSW	Director, Child Witness to Violence Program, Boston Medical Center

Jack Hagenbuch	Wayside Youth & Family Support Network
Kim Hale	President, Gateways for Kids
Julie Hall, Esq.*	Children and Family Law Program, Committee for Public Counsel Law Services
Ray Hammond, MD, MA	Pastor, Bethel AME Church; and President, Ten Point Coalition
Diane Harold	Acting Director, Collaborative Assessment Program, DSS – Boston Region
Gordon Harper, MD*	Medical Director, Children & Adolescent Services, Massachusetts Department of Mental Health (DMH)
Constance M. Hilton	Attorney at Law
Mark Hinderlie*	President, Boston Children's Institute
Richard Ho	Massachusetts Department of Social Services (DSS)
Barry L. Hock	Kids Count Coordinator, Massachusetts Citizens for Children
Sharon Hoey	Executive Director, Advocacy Center for Children
Nancy Horber	Program Manager, DSS – Brockton Area
Stephanie Howard, PhD	Children's Charter, Inc.
Denise Howley	Deputy Executive Director, Germaine Lawrence, Inc.
Philip W. Johnston*	President, Philip W. Johnston Associates
Hubie Jones	Special Assistant to the Chancellor, University of Massachusetts
Christina Joyce	Area Director, DSS - Brockton Area
Carin Kale	Executive Office of Health and Human Services
Dolores Kane	Wediko Children's Services
Amy Karp, Esq.	Training Director, Children and Family Law Program CPCS
Bill Keaney, PhD*	Assistant Director of Field Education, Boston College School of Social Work
Robert Kelley	Regional Director, DSS – Southeast Region
Ed Kelly	Executive Director, Robert F. Kennedy Children's Action Corps
Martin Kenney	Area Director, DSS – Attleboro Area
Patricia Kiessling*	Manager, Family Based Services, Children and Family Services of Greater Boston
Roderick K. King, MD, MPH*	Director, Boston Field Office, Health Resources & Services Administration, U.S. Dept of Health and Human Services
Robert Kinscherff, PhD*	Director, Juvenile Court Clinic Services, Trial Court of the Commonwealth
Gail Klopfer	Program Manager, DSS – Robert Van Wart Center
Alice Kubacki	Regional Director, DSS – Northeast Region
Joe Langione	Wediko Children's Services
Nancy Langman-Dorwart	Bristol Group, Inc.
Laurie Larkin	Wediko Children's Services
Craig Latham, PhD	Forensic Psychologist
Ellen Lawton, Esq.*	Staff Attorney, Family Advocacy Program, Boston Medical Center
Joseph Leavey	Executive Director, Communities for People, Inc.
Marilyn Lee-Tom	Massachusetts Law Reform Institute
Hugh Leichtman, PhD*	Administrative Director, Wediko Children's Services
Sarah Levy	Greater Boston Legal Services
Jeffrey Locke, Esq.	Commissioner, DSS

Sandra Lopacki	Harvard School of Public Health
Joan Louden-Black	Assistant Commissioner, Placement and Family Based Services, DSS
JoAnne Luppino	Director, Dorchester CARES
Ann Marie Lynch	Area Program Manager, DSS – Harbor Area
Ed J. Malloy, Jr., LICSW*	Supervisor, DSS
Melinda Marble	Director, The Paul and Phyllis Fireman Charitable Foundation
Steve McCafferty	Executive Director, Children's Study Home
Claire McCarthy, MD*	Martha Eliot Health Center
Kathleen McCarthy	Program Manager, DSS – Hyde Park Area
Robert McGowan	Principal, Bristol Group, Inc.
Joan McGregor*	Director of Special Projects, DSS
Peggy McLaughlin	Victim Witness Advocate, Office of Plymouth County District Attorney
Patricia McMahon	Program Manager, DSS – Arlington Area
Jay McManus*	Executive Director, Children's Law Center of Massachusetts
Gail Medeiros	Area Director, DSS – Lowell
Veronica Melendez*	Administration for Children & Families, U.S. Department of Health and Human Services, Region I
Neal Michaels	Director, Family Based Services, DSS
Joan Mikula	Assistant Commissioner, Child & Adolescent Services, DMH
Barbara Mitchell, Esq.	Greater Boston Legal Services
Kathleen Morrissey	Director, Victim Witness Assistance Program, Criminal Bureau, Office of the Attorney General
Richard Murphy	Regional Clinical Manager, DSS - Western Region
Eli Newberger, MD	Assistant Professor of Pediatrics, Harvard Medical School; and Lecturer, Maternal and Child Health, Harvard School of Public Health
Lisa Noe*	Child Advocacy Center Coordinator, Office of Plymouth County District Attorney
Thomas J. O'Loughlin*	Chief, MBTA Police Department
Lori Ortiz	Area Program Manager, DSS – Lawrence Area
Sarah Ovenden	CAC Project Coordinator, Office of Northwestern District Attorney
Susan Pederzoli	Assistant Commissioner, Clinical Services & Intergovernmental Affairs, DSS
Raymond Pillidge	Area Program Manager, DSS – Haverhill Area
Maureen Pompeo*	President, Galloglass Consulting
Stephen G. Porter, MD	Private Practice
Anita Preble, MS*	Social Worker, Day Care Programs, Community Teamwork, Inc.
Nancy Prostak	Acting Area Director, DSS – North Central Area
Robert L. Quinan	Office of the Attorney General
Aileen Quintero	Victim Witness Advocate, Office of Plymouth County District Attorney
Debbie Rambo, LICSW*	Director of Services, Catholic Charities (Boston)
Robert Reece, MD*	Clinical Professor of Pediatrics, Institute for Professional Education, Mass. Society for the Prevention of Cruelty to Children (MSPCC)
Olga Roche	Acting Area Director, DSS - Worcester Area
Allan G. Rodgers, Esq.*	Executive Director, Massachusetts Law Reform Institute
Laurie Roy	Area Program Manager, DSS – William E. Warren Center Area

Jacqueline Rufo	Commissioner's Office, DSS
Owen Ryan	Area Program Manager, DSS – South Central / Blackstone Valley Area
Bonny B. Saulnier	Vice President, Wayside Youth & Family Support Network
Mark Sawula	Area Program Manager, DSS – Springfield Area
Glenn Saxe, MD	Chairman of Child Psychiatry, Boston Medical Center
Ufuk Sezgin	Victims of Violence, Office of the Attorney General
Steven N. Shapse, PhD	Psychologist in Private Practice
Sharon Shay	President, Family Nurturing Center
Richard Sherman, LICSW*	Director of Public Policy, NASW – Massachusetts Chapter
Jack Simons, PhD	Director of Professional Services, Children's Friend and Family Services
Nora Sjoblom Sanchez, Esq.*	Children's Policy Analyst, Massachusetts Citizens for Children
Christopher Small	Executive Director, Italian Home for Children
Carla Smith Picariello, PhD	Children and the Law Program, Massachusetts General Hospital
Pat Snyder-Mathews	Director, Child Abuse Project, Office of Essex County District Attorney
Cathy Speraw	Harvard School of Public Health
Barbara St. Pierre, LICSW	Director of Social Services, Child Development Programs of Cape Ann
Kim Stevens	Program Director of Education & Training, Children's Services of Roxbury
Frederick J. Stoddard, MD	Massachusetts Psychiatric Society
Joyce Strom*	President and CEO, MSPCC
Barbara Sullivan*	Special Committee on Family Support and the Child Welfare System
Michael J. Sullivan, Esq.	District Attorney, Plymouth County
Sarah Jane Swart	Editorial Director, Group & Online List Coordinator, Adoptive Families Together
Julie Sweeney-Springwater*	Director, New England Association of Child Welfare Commissioners & Directors
Barbara Talkov	Executive Director, Children's League of Massachusetts
Jacqueline Taylor	Wediko Children's Services
April Thibeault	Miss Massachusetts 1999
Robert Turillo	Northeast Regional Manager, Massachusetts Behavioral Health Partnership
Thomas N. Turner, Esq.	Attorney at Law
Kathleen Tuttman, Esq.	Assistant District Attorney, Office of the Essex County District Attorney
MaryAnn Ulevich	Director of Child Welfare Development, Children's Friend, Inc.
Bessel van der Kolk, MD	Director, Trauma Center at Arbour – HRI
David Van Kennan	Social Worker IV, DSS – North Central Area
Mary E. Walsh, PhD	Director, Boston College Center for Child, Family and Community Partnerships
Valora Washington, PhD	Executive Director, Unitarian Universalist Service Committee
Peter Watson	Director of Quality Assurance, Domestic Violence & Family Support Unit, DSS
Charles Welch, MD*	Director of Somatic Therapies, Massachusetts General Hospital; and Vice President, Massachusetts Medical Society
Debra Whitcomb	Education Development Center, Inc.
Kathryn A. White	Trial Court of the Commonwealth
Ronald E. White, PhD	Associate Director, Bear, Stearns & Company, Inc.

Sandra White, MEd	Private Citizen
Pam Whitney	Director, Domestic Violence & Family Support Unit, DSS
Julie Boatright Wilson	Director, Malcolm Wiener Center for Social Policy, Harvard University JFK School of Government
Margaret Winchester, Esq.	Co-Director, Children and Family Law Program, Committee for Public Counsel Law Services
Hendrik Workman	Area Program Manager, DSS – New Bedford Area
Tera Wright, Esq.	Chief, Family Protection Unit, Office of Plymouth County District Attorney

Out of State Participants and Consultants

Susan Nall Bales	President, FrameWorks Institute, Maryland
Marno Batterson	Site Coordinator, Community Partnerships, Iowa
Brett Brown	Senior Research Associate, Child Trends, Inc., Washington, DC
Anne Cohn Donnelly, DPH	Consultant, National Call to Action, IL
Howard Davidson, JD	Director, ABA Center for Children and the Law, Washington, DC
Heitzi Epstein, Esq.	Senior Policy and Advocacy Specialist in Child Welfare, National Association of Child Advocates, Washington, DC
Jann Jackson	Executive Director, Maryland Advocates for Children and Youth
A. Sidney Johnson, III	President and CEO, Prevent Child Abuse America, Chicago, IL
Mark Katz, PhD	Director, Learning and Developmental Services, San Diego, CA
Susan Notkin	Director, The Program for Children, Edna McConnell Clark Foundation, New York, NY
David Osher, PhD	Director, Center For Effective Collaboration and Practice, American Institutes for Research, Washington, DC
Lynn Porter	Executive Director, Safer Society Foundation, Inc., Brandon, VT
Pat Schene, PhD	Consultant, Edna McConnell Clark Foundation, New York, NY
Linda Spears	Associate Deputy Director, Programs, Research, and Consultation Child Welfare League of America, Washington, DC
Anna Stone, MSW, LCSW	Missouri Department of Social Services
Ben Tanzer	Chapter Technical Assistance Coordinator, Prevent Child Abuse America, Chicago, IL
Paul Vincent, MSW, LICSW	Director, The Child Welfare and Policy Group, Montgomery, AL
Jay Whitworth MD	Executive Medical Director, Florida Child Protection Teams
Betsy Wood, RN, MPH	Unit Director, Florida Department of Health

Appendix C

Unduplicated Counts of Reported Children by Incorporated City/Town during January 1 – December 31, 1997[1]

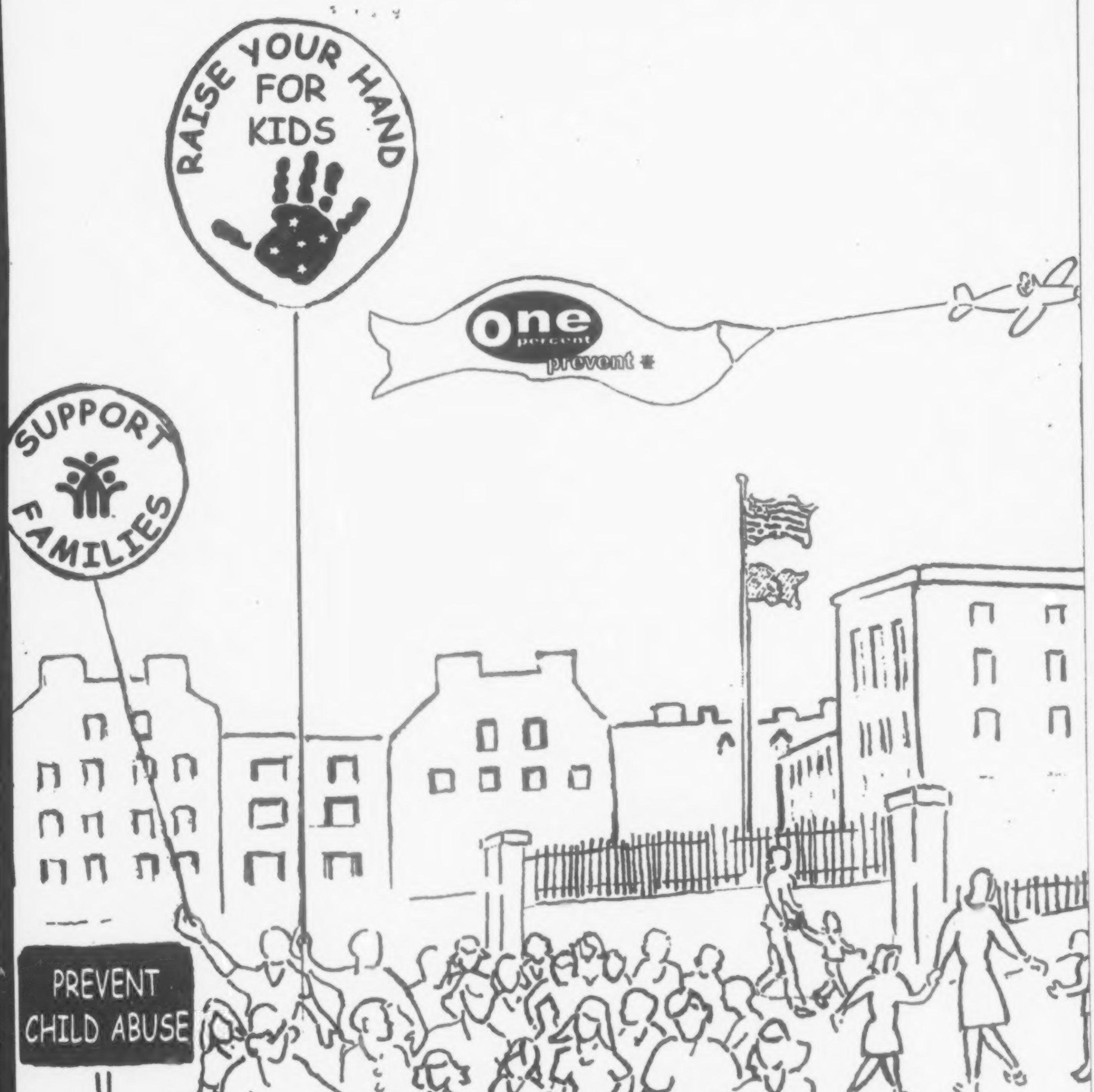
City[2]	Reported Children No.	Reporting Rate[3] (per 1,000)
Holyoke	1,641	128
Greenfield	445	106
North Adams	352	105
Lynn	2,198	104
Brockton	2,238	95
Lawrence	2,052	95
Pittsfield	966	94
Chelsea	787	89
Fall River	1,850	85
New Bedford	2,067	84
Chicopee	1,021	83
Fitchburg	692	77
Springfield	3,189	76
Lowell	2,087	75
Revere	656	75
Yarmouth	305	74
Worcester	2,830	73
Boston	7,765	71
Barnstable	676	70
Salem	549	67
Haverhill	961	67
Gardner	308	66
West Springfield	409	65
Wareham	320	63
Westfield	578	61
Southbridge	276	60
Framingham	763	59
Taunton	751	58
Gloucester	344	58
Somerville	633	57
Everett	411	55
Falmouth	372	55
Malden	511	51
Beverly	418	51
Plymouth	634	49
Quincy	676	47
Marlborough	350	47
Cambridge	621	45
Leominster	443	44
Methuen	445	44
Medford	430	43
Attleboro	437	42
Peabody	404	41
Woburn	285	40
Weymouth	402	37
Waltham	333	36
MASSACHUSETTS	**69,943**	**50**

---

[1] A child is counted only once, regardless of the number of times reported during the year.

[2] Residence of reported children on January 17, 1998. Selected only those cities or towns in Massachusetts which had 275 (unduplicated) or more children in residence who were reported.

[3] Number of reported children per 1,000 resident children under 18 years old.


RAISE YOUR HAND FOR KIDS
one percent prevent
SUPPORT FAMILIES
PREVENT CHILD ABUSE
MASSACHUSETTS
CAMPAIGN FOR CHILDREN
PAUL D. SHEA